Bruceville Dental

HEALTH HISTORY

PATIENT NAME: ____ ACCOUNT #: ______________________

To be completed with patient's information only. Please answer every question and circle Y or N where applicable.

Are you in good health? **Y N**
Are you under the care of a physician? **Y N**
If so, what is the condition being treated? ________________________
Physician name:______________________ Phone No:_____________
Address:____
City:_________________________ State: _______Zip:_____________
Have you ever had a serious illness or operation? **Y N**
If so, what illness or operation? ______________________________

Date of last physical examination: _____/_____/_____
Have you ever been hospitalized? **Y N**
If so, why? ______________________________________
Are you taking any medication? **Y N**
If so, what?__________________ Dosage:_____________
Are you using any recreational drugs (marijuana, etc.)? **Y N**
If so, what?____
Frequency:____

Have you ever had any disease, medication, or transplant operations that have depressed your immune system? **Y N**
Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or cancer (i.e. Reclast, Fosamax, Actonel, Boniva, etc.)? **Y N**
Have you ever been premedicated with antibiotics for dental treatment? **Y N**
Do you have any allergies? If yes, to what? ____ **Y N**

❑ Latex ❑ Penicillin ❑ Tetracycline ❑ Sulfa Drugs ❑ Aspirin ❑ Codeine ❑ Other:____________________

Do you have, or have you ever had any of the following (Please circle **Y** or **N**, answer all conditions):

Condition			Condition			Condition			Condition		
Anemia	**Y**	**N**	Bruise Easily	**Y**	**N**	Tuberculosis (TB)	**Y**	**N**	Respiratory Disease	**Y**	**N**
Herpes	**Y**	**N**	Abnormal Bleeding	**Y**	**N**	Rheumatic Fever	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**
Stroke	**Y**	**N**	Head Injuries	**Y**	**N**	Blood Transfusion	**Y**	**N**	Psychiatric Treatment	**Y**	**N**
Ulcers	**Y**	**N**	Autism	**Y**	**N**	Joint Replacement	**Y**	**N**	Hepatitis or Jaundice	**Y**	**N**
Diabetes	**Y**	**N**	Scarlet Fever	**Y**	**N**	Nervous Disorders	**Y**	**N**	Difficulty in Swallowing	**Y**	**N**
Glaucoma	**Y**	**N**	Sinus Trouble	**Y**	**N**	Tumors or Growths	**Y**	**N**	Heart Ailments	**Y**	**N**
Arthritis	**Y**	**N**	Heart Murmur	**Y**	**N**	Allergies or Hives	**Y**	**N**	Congenital Heart Lesions	**Y**	**N**
Hay Fever	**Y**	**N**	Liver Disease	**Y**	**N**	Pain in Jaw Joints	**Y**	**N**	Radiation, X-ray or Cobalt Treatment	**Y**	**N**
Tonsil Issues	**Y**	**N**	Blood Disorder	**Y**	**N**	Artificial Prosthesis	**Y**	**N**	Fainting Spells, Epilepsy or Seizures	**Y**	**N**
Asthma	**Y**	**N**	Drug Addiction	**Y**	**N**	Sickle Cell Disease	**Y**	**N**	Chemotherapy (Cancer, Leukemia)	**Y**	**N**
Hemophilia	**Y**	**N**	Kidney Disease	**Y**	**N**	Cortisone Medicine	**Y**	**N**	Treatment for Tumors/Growths (not X-ray Therapy)	**Y**	**N**
Cold Sores	**Y**	**N**	Stomach Ulcers	**Y**	**N**	Allergies to Metals	**Y**	**N**	ADD or ADHD	**Y**	**N**
Breathing Issues	**Y**	**N**	Angina Pectoris	**Y**	**N**	Excessive Bleeding	**Y**	**N**	Acquired Immune Deficiency Syndrome (AIDS)	**Y**	**N**
Rheumatism	**Y**	**N**	Mental Disorder	**Y**	**N**	High Blood Pressure	**Y**	**N**	TMJ (Temporomandibular Joint) Disorder	**Y**	**N**
Chicken Pox	**Y**	**N**	Cerebral Palsy	**Y**	**N**	Low Blood Pressure	**Y**	**N**	Impaired Vision, Hearing or Speech: ________	**Y**	**N**
Osteoporosis	**Y**	**N**	Thyroid Disease	**Y**	**N**	HIV Related Complex	**Y**	**N**	Tobacco Products: ______________________	**Y**	**N**

Is there anything you would like to discuss with the Doctor in private? **Y N**
Do you wear a prosthesis? ______________________________ **Y N**
Have you had heart surgery? If so, when? ___________________ **Y N**
Have you ever been advised NOT to take a medication? **Y N**
If yes, what? _______________________ When?___________
Have you ever had local anesthetic (Novocaine, etc)? **Y N**
Have you ever had a reaction from local anesthetic? **Y N**
If yes, explain____
How long since your last full mouth x-rays?
Weeks ________ Months _______ Years _______

Do you have any past history of alcohol/chemical dependency or emotional disorder that may affect the care we provide to you? **Y N**
Do you have a disease or condition not listed above? **Y N**
If yes, what?____
Have you ever taken the drugs "Phen-Phen" or "Redux"? **Y N**
If yes, which one?___________________ When?___________
Have you ever had excessive bleeding after your dental work? **Y N**
Have you ever had trouble associated with dental work? **Y N**
If yes, explain____
How long since last dental treatment?
Weeks ________ Months _______ Years _______

Females:

Are you pregnant? **Y N**
If yes, how many weeks? ______________

Any problems associated with menstrual cycle? **Y N**
Currently taking birth control pills? **Y N**

Comments:

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I have filled out this questionnaire completely. I have advised you of all medical problems of which I am aware and I authorize and give full consent to perform dental services agreed between doctor and patient to be necessary or advisable, including examination, radiographs, local anesthetics and other medications as indicated. I am responsible for payment on all work performed regardless of my insurance coverage and hereby assign payment of my insurance benefits to the provider of services.

Signature: ____ Date: ______________________
If Minor, Parent or Legal Guardian

Doctor Signature: ______________________________________ Date: ______________________

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