HEALTH HISTORY

Mr. Mrs. Ms. Dr. — Home Phone #
Address — Cell #
City — State — Zip — Date of Birth
Occupation — Email — Social Security #
Business Name and Address — Business #
Emergency Contact Name — Phone #
Who referred you to our office?

DENTAL INFORMATION

Yes	No	Don't know	
○	○	○	Are you having discomfort?
			Explain:
○	○	○	Has a physician ever recommend that you take antibiotics prior to dental treatment?
○	○	○	Do you currently take antibiotics prior to dental treatment?
○	○	○	Have you had a serious/difficult prohlem associated with dental treatment?
			If so, please explain:

MEDICAL INFORMATION

○	○	○	Do you feel well (healthy) today?
○	○	○	Are you in good health?
○	○	○	Has there been any change in your general health within the past year?
○	○	○	Do you smoke?
			How many years have you smoked?
			How much do you smoke daily?

Do you have any of the following diseases or prohlems?

○	○	○	Active Tuberculosis
○	○	○	Persistant cough
○	○	○	Are you under the care of a physician? If so, what is/are the condition(s) heing treated? (i.e. HeartIBlood pressure)

Physicians Name/Address: — Phone #

Yes	No	Don't know	
○	○	○	Any fever, malaise or change in weight in the last 2 weeks?
○	○	○	Have you had any serious illness, operation or been hospitalized in the past 5 years?
○	○	○	Are you alcohol and/or drug dependent?
○	○	○	Do you use drugs o,r other substances for recreational purposes?
○	○	○	Are you taking or have you recently taken any medicine(s)including non-prescription medicine (over the counter)? If so, what medicine(s) and dosage are you taking?
			List all medications and dosages:

Allergies: Are you allergic to or have you had a reaction to:

Yes	No	Don't know		Yes	No	Don't know	
○	○	○	Local anesthetics	○	○	○	Latex, BandAids, Rubber
○	○	○	Aspirin	○	○	○	Barbiturates, Sedatives
○	○	○	Penicillin	○	○	○	Sulfa drugs
○	○	○	Codeine or other narcotics	○	○	○	Food
			Other (Specify):				

If yes response to any allergy, specify type of reaction:

(Women Only)

Yes	No	Don't know	
○	○	○	Are you pregnant?
○	○	○	Taking birth control pills? (Antibiotics may inactivate birth control pills.)
○	○	○	Nursing?

BONACCI
Periodontics & Dental Implants, LLC
- BOARD CERTIFIED PERIODONTIST -

HEALTH HISTORY (page 2)

Please check YES or NO to the following diseases or problems.

Yes	No	Don't Know		Yes	No	Don't Know	
			Abnormal bleeding				Heart Attack
			Aids or HIV infection				Heart Murmur
			Anemia				High Blood Pressure
			Angina				High Cholesterol
			Arthritis				Hip Replacement
			Artificail Heart Valves				Kidney Problems
			Asthma				Knee Replacement
			Cancer/chemotherapy/radiation				Mental Health Disorders
			Chest Pains Upon Exertion				Mitral Valve Prolapse
			Chronic Pain				Pacemaker
			Claustrophobic				Persistent Diarrhea
			Diabetes				Recurrent Infections
			Disease, Drug or Radioinduced				Respiratory Problems
			Immunosuppression				Rbeumatic Heart Disease
			Epilepsy				Sinus Trouble
			Esophageal Reflux				Stroke
			Excessive Urination				Tbyroid Problems
			Fainting Spells or Seizures				Ulcer, Heartburn
			Glaucoma				

Do you bave any disease, condition or problem not listed above that you think we should know about? If so, please explain:

Note: Both the doctor and patient are encouraged to discuss any other relevant patient issues prior to treatment. I consent to have-necessary examination; x-rays; periodontal surgery or implant related surgery; local anesthesia. I acknowledge that I am responsible (for fees) for services rendered. r understand that if there arc any post-operative problems or misunderstandings it is my obligation to return. I certify that I have read and understand the above. r acknowledge that my questions, if any, about inquiries set forth above bave been answered to my satisfaction.

Signature of PatientlLegal Guardian _____ Date _____

Below for completion by Dentist
Comments on patient interview concerning health history:

Significant Findings:

Dental management considerations:

Signature of Dentist _____ Date _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, dates and comments, along with signature.

Date _____ Comments _____ Signature of patient and dentist _____