inner city
HEALTH CENTER
Your Doctor. Your Dignity.

Health History

Patient Name: _____ DOB: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning you health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Do you have any of the following diseases or problems: Yes (Y) or No (N)

1. Active Tuberculosis _____
2. Persistent cough greater than 3 weeks duration _____
3. Cough that produces blood _____
4. Been exposed to anyone with tuberculosis _____

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information:

Are you now under the care of a physician? _____ Date of last examination: _____

Name of physician: _____ Physician phone number: _____

Are you in good health? _____ Has there been any change in your general health within the past year? _____

If yes, what condition is being treated? _____

_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? _____

If yes, what was the illness or problem? _____

_____

Are you taking or have you recently taken any prescription or over the counter medicines? _____ If so, please list all, including vitamins, natural or herbal preparations, and/or diet supplements: _____

_____

Women Only: Yes (Y) or No (N) - Are you**:**

Pregnant? ____ If yes, number of weeks ____

Taking birth control pills or hormonal replacement? ___ Nursing? ___

Joint Replacement: Yes (Y) or No (N)

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ____ Date _____

If yes, have you had any complications? ____

_____

Other: Yes (Y) or No (N)

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ____

Since 2001, were you treated or are you scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? ____

Date treatment began: _____

_____

Do you smoke or ingest marijuana? ____

Do you use recreational drugs? ____

Do you use prescription pain medications? ____

How much alcohol do you typically drink in a week? _____

_____

Allergies: Are you allergic to or have you had an allergic reaction to the following: **Yes (Y) or No (N)**

Local anesthetics(numbing medicine) ___ Aspirin ___ Penicillin or other antibiotics ___ Sulfa Drugs ___

Codeine ___ Barbiturates, sedatives, or sleeping pills ___ Metals ___ Latex ___ Allergy medicines ___

Iodine ___ Animals ___ Food _____ Other _____

Have you had any of the following diseases or medical problems? Yes (Y) or No (N)

Artificial heart valve ___	Previous infective endocarditis ___	Damaged valves in transplanted heart ___
Congenital heart disease ___	Cardiovascular disease ___	Angina ___
Congestive heart failure ___	Damaged heart valves ___	Heart attack ___
Heart Murmur ___	Low blood pressure ___	High blood pressure ___
Mitral valve prolapse ___	Other congenital heart defects ___	Blood transfusion ___ (date) _____
Rheumatic fever ___	Rheumatic heart disease ___	Anemia ___
Abnormal bleeding ___	Hemophilia ___	AIDS/HIV infection ___
Auto-immune disease ___	Rheumatoid arthritis ___	Hepatitis or liver disease ___
Asthma ___	Bronchitis ___	Emphysema ___
Sinus trouble ___	Epilepsy ___	Fainting spells/seizures ___
Neurological disorders ___	Sleep disorders ___	Kidney problems ___
Diabetes Type 1 or 2 ___	Eating disorder ___	Osteoporosis ___
Gastrointestinal disease ___	Gastrointestinal reflux ___	Persistent heartburn ___
Ulcers ___	Thyroid problems ___	Severe/rapid weight loss ___
Night sweats ___	Persistent swollen glands in neck ___	Stroke ___
Glaucoma ___	Excessive urination ___	Severe headaches/migraines ___
Recurrent infections ___	Sexually transmitted disease ___	High cholesterol ___

Mental health disorders ___ (specify- _____)
Cancer, chemotherapy/radiation treatment ___
Other problems not listed _____
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ____

_____

Dental Information:

Reason for today's visit: _____

_____

Name of previous dentist: _____ Phone: _____

Date you last saw a dentist: _____

Date of last dental exam: _____

Date of last full mouth x-rays: _____

Have you had periodontal therapy (deep cleanings)? _____ Yes No Don't know

Are your teeth sensitive to hot, cold, sweets, or pressure? _____ Yes No Don't know

Do you grind or clench your teeth? _____ Yes No Don't know

Have you had problems with local anesthetics(numbing medicine)?_____ Yes No Don't know

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Dentist Signature: _____ Date: _____

Dentist Comments: _____

_____

_____

_____