WOODLAND FAMILY DENTISTRY

Medical Alert:	Premedication:	Allergies:

HEALTH HISTORY FORM

Name:_____ DoB: _____ Pronoun: ☐ He ☐ She ☐ They

Address:_____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Business Phone: _____

SS#:_____ Email: _____ Occupation:_____

ADULTS: Emergency Contact: _____ Relationship:_____ Phone:_____

CHILDREN UNDER 18: Custodial Parent #1:_____ Custodial Parent #2:_____

RECENT HEALTH CONCERNS

	Yes	No
Have you had a stroke or heart attack in the last 6 months?	☐	☐
Have you had a joint replacement or heart valve surgery in the last 6 months?	☐	☐
Have you had any health problems, operations, or been hospitalized in the past 5 years?	☐	☐

If yes, please explain: _____

_____

_____

_____

Primary Physician: _____
NAME LOCATION

Specialist: _____
NAME LOCATION SPECIALTY

Specialist: _____
NAME LOCATION SPECIALTY

Specialist: _____
NAME LOCATION SPECIALTY

	Yes	No
Are you alcohol and/or drug dependent?	☐	☐
Do you use tobacco (smoking, snuff, chew, e-cig, vaping)?	☐	☐

If yes, how interested are you in stopping?

(circle one) Very / Somewhat / Not Interested

MEDICATIONS

	Yes	No
Have you ever taken bisphosphonate or other bone strengthening medications?	☐	☐

IV FORM?_____ Other? _____

Are you taking blood thinners?	☐	☐

Please list all medication and reason you are taking (including over-the-counter and supplements):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

WOMEN ONLY

	Yes	No
Are you or could you be pregnant?	☐	☐
Nursing?	☐	☐

PLEASE COMPLETE BOTH SIDES

ALLERGIES

Please check a response and add date where applicable.

Are you allergic to or had a reaction to any of the following:	**Yes**	**No**
Latex	☐	☐
Local anesthetics	☐	☐
Aspirin/Ibuprofen/NSAIDS/Acetaminophen	☐	☐
Penicillin	☐	☐
Sulfa drugs	☐	☐
Other antibiotics (please list) _____		
_____		
_____		
Barbiturates, sedatives, or sleeping pills	☐	☐
Codeine or other narcotics	☐	☐
Iodine	☐	☐
Other: (eg. animals, seasonal, metals, food, etc.)	☐	☐
Please specify: _____		

PRE-MEDICATION

	Yes	**No**
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
If yes, when was this operation done? _____		
_____		
If yes to the above question, have you had any complications or difficulties with you prosthetic joint?	☐	☐
Do you have a congenital heart defect or had surgery to repair a heart valve?	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment?	☐	☐
If yes, what antibiotic and dose? _____		
Name of physician or dentist: _____		
Phone: _____		

To yes allergy responses, specify type of reaction:_____

_____

ADDITIONAL HEALTH HISTORY

Please circle if you have or have had any of the following diseases or problems. Add date where applicable.

CARDIOVASCULAR DISEASE

Heart attack Date: _____
Pacemaker/defibrillator
Artificial heart valve/Congenital heart defect
High blood pressure
Angina
Mitral valve prolapse/Heart murmer
Congestive heart failure
Sleep apnea
Other: _____

PULMONARY DISEASE

Asthma
Emphysema/COPD/Chronic Bronchitis
Type of inhaler: _____
Pulmonary Disease
Tuberculosis

GASTROINTESTINAL DISEASE

GE Reflux
GERD
History of C-Diff Infection
Eating Disorder (please specify)
_____

ENDOCRINE/METABOLIC

Diabetes: ☐ Type I (insulin dep) ☐ Type II
Kidney Disease
Dialysis
Thyroid problems
Hepatitis
Liver Disease

IMMUNOLOGIC

Auto-Immune Disease Type: _____
Rheumatoid Arthritis
AIDS or HIV infection
Systemic Lupus Erythematosus
Disease, drug, radiation-induced immunosuppression

HEMATOLOGIC/ONCOLOGIC

Cancer Type/Date: _____
Blood clots Date: _____
Anemia
Abnormal Bleeding
Hemophilia
Blood transfusion

NEUROLOGICAL/PSYCHOLOGICAL

Stroke Date: _____
Epilepsy/Seizures
Neurological disorder Type:_____
Depression/Anxiety
Mental Health Disorder Type: _____
Autism
ADD
ADHD

☐ **NONE OF THE ABOVE HEALTH ISSUES**

*Please list and explain any other disease, condition, problem not listed above that we should know about.

_____
_____
_____
_____
_____
_____

NOTE: Both Doctor & 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. 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 his/her 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.

X _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**