# WOODLAND FAMILY DENTISTRY

| Medical Alert: | Premedication: | Allergies: |
|---|---|---|
| | | |

## HEALTH HISTORY FORM

Name:_____ Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Other: _____

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

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

SS#:_____ Emergency Contact: _____ Relationship:_____ Phone:_____

DoB: _____ Email: _____ Occupation:_____

What brings you to the office today? _____

## RECENT HEALTH CONCERNS

| | Yes | No |
|---|---|---|
| Have you had a known exposure to someone with Covid-19 or symptoms of Covid-19 in the past 14 days? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| Do you have Tuberculosis? | ☐ | ☐ |

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

| | | |
|---|---|---|
| Have you had any health problems, operations, or been hospitalized in the past 5 years? | ☐ | ☐ |

If yes, please explain: _____

## 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):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

## 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 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, when was this operation done? _____

_____

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: _____
Blood Clots Date: _____
High blood pressure
Low blood pressure
Angina
Arteriosclerosis
Artificial heart valve
Congenital heart defect
Coronary artery disease
Heart murmur
Mitral valve prolapse
Pacemaker/defibrillator
Rheumatic heart disease/fever

**PULMONARY DISEASE**

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

**GASTROINTESTINAL DISEASE**

GE Reflux
GERD
Eating Disorder (please specify)
_____

**ENDOCRINE/METABOLIC**

Diabetes: _____ Date: _____
☐ Type I (insulin dependent)
☐ Type II
Most recent A1C level? _____
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**

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

**NEUROLOGICAL/PSYCHOLOGICAL**

Stroke Date: _____
Neurological disorder Type:_____
Depression
Mental Health Disorder
Epilepsy/Seizures
Fainting spells
Severe Headaches/Migraines
Chronic Pain

☐ 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.*

**SIGNATURE OF PATIENT OR LEGAL GUARDIAN** **DATE**