Deluxe Dental

DENTISTRY FOR KIDS & ADULTS

Phone: (248) 274-4020

Health History

Patient's Name ____________ Date of Birth ____________ Weight ____________ Date ____________

Answer all questions by checking Yes (Y) or No (N)

1. Are you in good health? ☐Y ☐N
2. Has there been any change in general health in the past year? ☐Y ☐N
3. Date of last physical exam: ____________________
4. Are you now under a physician's care for a particular problem? ☐Y ☐N
5. Have you ever had any serious illnesses, hospitalizations, or operations? If so, describe: ☐Y ☐N
6. Do you have any problems OR have you been told you stop breathing while sleeping OR you snore? ☐Y ☐N
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Congenital Heart Disease? ☐Y ☐N
   - B. Cardiovascular Disease (Heart Attack, Arteriosclerosis, Coronary Artery Disease, Angina, Stroke, palpitations, Heart Surgery)? ☐Y ☐N
   - C. Artificial heart valves, artificial Joints (hip replacement, knee replacement, etc.)? ☐Y ☐N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐Y ☐N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ☐Y ☐N
   - F. Bleeding disorder, anemia, bleeding tendency, Blood Transfusion? Do you bruise easily? ☐Y ☐N
   - G. Liver Disease (Jaundice, hepatitis)? ☐Y ☐N
   - H. Kidney Disease? ☐Y ☐N
   - I. Diabetes? ☐Y ☐N
   - J. Thyroid Disease (Goiter)? ☐Y ☐N
   - K. Arthritis? ☐Y ☐N
   - L. Stomach Ulcers or Colitis ☐Y ☐N
   - M. Glaucoma? ☐Y ☐N
   - N. Osteoporosis? ☐Y ☐N
   - O. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or cancers (Reclast, Fosamax, Actonel, Bonlva, Zometa)? ☐Y ☐N
   - P. Cancer? Type? ____________________ ☐Y ☐N
   - Q. Radiation (X-ray) treatment for Cancer? ☐Y ☐N
   - R. Chemotherapy? ☐Y ☐N
   - S. Clicking or popping of jaw Joint, pain near ear, or difficulty opening mouth? ☐Y ☐N
   - T. Clench or grind your teeth? ☐Y ☐N
   - U. Sinus or Nasal problems? ☐Y ☐N
   - V. Any disease, drug, or transplant operation that has depressed your immune system? ☐Y ☐N
   - W. HIV/AIDS? ☐Y ☐N
8. ARE YOU USING ANY OF THE FOLLOWING
   - A. Antibiotics ☐Y ☐N
   - B. Anticoagulants (Blood thinners) ☐Y ☐N
   - C. Aspirin or drugs such as Motrin, Aleve, ibuprofen? ☐Y ☐N
   - D. High Blood Pressure medications? ☐Y ☐N
   - E. Steroids(CortisOne, Prednisone, etc.)? ☐Y ☐N
   - F. Insulin or Oral Anti-Diabetic drugs? ☐Y ☐N
   - G. Digitalis, Inderal, Nitroglycerin or other heart drugs? ☐Y ☐N
   - H. Have you ever been advised NOT to take a medication? ☐Y ☐N
   - I. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, or holistic remedies, vitamins or minerals:
9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia? ☐Y ☐N
   - B. Penicillin or other antibiotics? ☐Y ☐N
   - C. Aspirin or Ibuprofen? ☐Y ☐N
   - D. Codeine or other pain killers? ☐Y ☐N
   - E. Latex or Rubber? ☐Y ☐N
   - F. Metal of any kind? ☐Y ☐N
   - G. Chemicals or Jewelry (rash or sensitivity)? ☐Y ☐N
   - H. Food products? ☐Y ☐N
   - I. Other allergies or reactions? Please list:
10. Do you smoke or chew tobacco? ☐Y ☐N
    How much per day?____________________
11. Is there any past History of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide? ☐Y ☐N
12. Have you had any serious problems associated with any previous dental treatment? ☐Y ☐N
13. Do you have any other disease, condition or problem not above that you think the doctor should know about? ☐Y ☐N
14. Do you wish to talk to the doctor privately about anything? ☐Y ☐N
15. FOR WOMEN ONLY:
    - A. Are you (potentially) Pregnant? ☐Y ☐N
    - B. Are you nursing? ☐Y ☐N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some others may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

I understand be importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date ____________ Signature of Person Completing Health History ____________ Doctor's Signature ____________