

Health History

JOSHUA B. BERNSTEIN



Name _____ Date _____

Have you been hospitalized in the last 5 years? (Please check one) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of medical care:

Medical physician currently providing you care:

Name _____ Phone (____) _____

- | | | | |
|---|--|-------------------------------------|--|
| Anemia or Blood Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis, Any Form | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Arthritis, Rheumatism or other inflammatory disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Joint Replacement When replaced? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Abnormal Bleeding from a cut | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease (including Jaundice) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cancer or Tumor | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sore/Enlarged Lymph Nodes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Psychosis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Emphysema or other Respiratory/Lung Illnesses | <input type="checkbox"/> No <input type="checkbox"/> Yes | Previous Biopsies | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Radiation or Chemotherapy Treatment | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fainting or Dizzy Spells | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Slow-Healing Mouth Sores | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Unintentional Weight Loss or Gain | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Valve (artificial) or Heart Transplant | <input type="checkbox"/> No <input type="checkbox"/> Yes | H.I.V. Infection/AIDS or ARC | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Venereal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Disease, Heart Attack or Heart Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other Conditions | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Stent? When placed? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Recurrent Illnesses | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Are you taking any of these medications?

- | | | | |
|---|--|--|--|
| Pre-medication before dental treatment? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tagamet® (cimetidine) or Prilosec® (omeprazole) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Antacids | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dilantin® or Tegretol® | <input type="checkbox"/> No <input type="checkbox"/> Yes | Serzone® (nefazodone) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Barbiturates | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diflucan® (fluconazole) or Sporonox® (itraconazole) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| St. John's Wort or Kava-Kava | <input type="checkbox"/> No <input type="checkbox"/> Yes | Biaxin® (clarithromycin) | <input type="checkbox"/> No <input type="checkbox"/> Yes |

COSMETIC DENTISTRY

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Health History — *continued*

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Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If yes, when did the treatment begin? _____
When did the treatment end? _____

Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking and dosages:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Women: Are you pregnant? No Yes

If not pregnant, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother No Yes

Are you taking Birth Control Pills No Yes

Have you ever been diagnosed with "abnormal" or "high blood pressure?" No Yes

Are you allergic or have you had a reaction to:

Local Anesthetics No Yes

Penicillin or antibiotics No Yes

Codeine, Valium or other sedatives No Yes

Aspirin, Ibuprofen or Tylenol No Yes

Latex or Metals No Yes

Other (please specify) _____

Tobacco, Alcohol & Drugs

Do you use tobacco? If yes, circle type: smoke No Yes
How much per day? _____ For how long? _____

Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? No Yes

Do you use any mood-altering drugs other than those previously listed? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

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Patient (Print Name) *(Patient Signature)* *Date*

Doctor (Print Name) *(Doctor Signature)* *Date*