Notchview Dental, L.L.P.
HEALTH HISTORY

____
Patient's Name

Answer all questions by circling Yes (Y) or No (N) - If yes, please explain.

1. Are you in good health? Y N ____________________
2. Has there been any change in your general health in the past year? Y N ____________________
3. Date of last physical exam____________________
   Name of physician____________________
4. Are you now under a physician's care for a particular problem? Y N ____________________
5. Have you ever had any serious illnesses, operations or hospitalizations? Y N ____________________
6. Are you pregnant? Y N ____________________
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   A. Rheumatic Fever or Rheumatic Heart Disease? Y N ____________________
   B. Congenital Heart Disease? Y N ____________________
   C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse)? Y N ____________________
   D. Lung Disease, Asthma, Emphysema, 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? Y N ____________________
   G. Do you bruise easily? Y N ____________________
   H. Liver Disease (Jaundice, Hepatitis)? Y N ____________________
   I. Kidney Disease? Y N ____________________
   J. Diabetes? Y N ____________________
   K. Thyroid Disease (Goiter)? Y N ____________________
   L. Arthritis? Y N ____________________
   M. Stomach Ulcers or Colitis? Y N ____________________
   N. Glaucoma? Y N ____________________
   O. Implants placed anywhere in your body or joint replacements (Heart Valve, Pacemaker, Hip, Knee)? Y N ____________________
   P Radiation (X-ray) treatment for cancer? Y N ____________________
   Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, swelling of lumps in mouth? Y N ____________________
   R. Sinus or Nasal problems? Y N ____________________
   S. Any disease, drug, or transplant operation that has depressed your immune system (HIV, A.I.D.S, ARC)? 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 ____________________

HEALTH HISTORY (Cont'd)

D. High Blood Pressure medications? Y N ______

E. Steroids (Cortisone, etc.)? Y N ______

F. Tranquilizers? Y N ______

G. Insulin or Oral Anti-Diabetic Drugs? Y N ______

H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N ______

I. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for osteoporosis or chemotherapy for multiple myeloma, etc.)? Y N ______

J. Please list any and all medications taken including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals.______

______

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocain, etc.?) Y N ______

B. Penicillin or other Antibiotics? Y N ______

C. Sedatives, Barbiturates? Y N ______

D. Aspirin or Ibuprofen? Y N ______

E. Codeine or other pain killers? Y N ______

F. Latex or Rubber products? Y N ______

G. Other allergies or reactions? Y N ______

Please list:______

10. Do you smoke or chew tobacco? Y N ______
11. Is there any past history of alcohol or chemical dependency/abuse? 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 listed above that you think the doctor should know about? Y N ______

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

______ Date ______ Signature of Person Completing Health History ______ Doctor's Initials

Former Dentist______ Phone ______

Date of Last Dental Exam and X-Rays:______ Type of treatment:______

List any difficulties with past treatment: ______

Chief oral complaint:______

What are you here for today: ______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

______ Patient ______ Date