## Notchview Dental, L.L.P. HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N) - If yes, please explain.  1. Are you in good health?  2. Has there been any change in your general health in the past year?  3. Date of last physical exam.  Name of physician.  4. Are you now under a physician's care for a particular problem?  5. Have you ever had any serious illinosses, operations of hospitalizations?  6. Are you pregnant?  7. No YOU HAVE OR HAVE YOU EVER HAD:  7. R. Rheumatic Fever or Rheumatic  8. Congenital Heart Disease (Heart Atlack, Heart Trouble, Heart Murmur, Coronary Artary Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse)?  9. Lung Disease, Asthma, Emphysema, Chronic Cough, Bronchilis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?  9. Esizuras, Convulsions, Epilopsy, Fainting or Dizziness of January (January).  9. Dizinesse (Januarice, Hepatitis)?  9. I. Kidney Disease (Jaundice, Hepatitis)?  10. Liver Disease (Jaundice, Hepatitis)?  11. Kidney Disease (Goiter)?  12. Liver Disease (Goiter)?  13. V. No.  14. Arthritis?  15. M. Stomach Ulcers or Coifitis?  16. M. Stomach Ulcers or Coifitis?  17. No.  18. Sinus or Nasal problems?  18. Antiosogulants (Blood Thinners)?  19. No.  19. Salations, Convulsion operation that has depressed op popping of jaw joint, pain near ear, difficulty opening mouth, swelling of tumps in mouth?  19. No.  20. Antibiotics?  20. Antibiotics?  21. Antibiotics?  22. Applind or drugs such as Motrin, Aleve, bupporter?  23. Applind or drugs such as Motrin, Aleve, bupporter?  24. No.  25. Applind or drugs such as Motrin, Aleve, bupporter?  26. Applind or drugs such as Motrin, Aleve, bupporter?  27. No.	Pa	atient's Name			
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F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion?  G. Do you bruise easily?  H. Liver Disease (Jaundice, Hepatitis)?  Y. N.  I. Kidney Disease?  Y. N.  J. Diabetes?  Y. N.  K. Thyroid Disease (Goiter)?  L. Arthritis?  Y. N.  M. Stomach Ulcers or Colitis?  N. Glaucoma?  O. Implants placed anywhere in your body or joint replacements (Heart Valve, Pacemaker, Hip, Knee)?  P. Radiation (X-ray) treatment for cancer?  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?  S. Any disease, drug, or transplant operation that has depressed your immune system (HIV, A.I.D.S, ARC)?  B. Anticoagulants (Blood Thinners)?  C. Asnirin or drugs such as Motrin Aleve			V	NI.	
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B. Anticoagulants (Blood Thinners)?  C. Aspirin or drugs such as Motrin, Aleve	8.				
C. Aspirin or drugs such as Motrin. Aleve		A. Antibiotics?	Y	N	
C. Aspirin or drugs such as Motrin. Aleve		D. A. C. L. (DL. LTC.)			
burrofen?			Y	N	
			Y	N	

## **HEALTH HISTORY (Cont'd)**

D. High Blood Pressure medications?	Υ	N
E. Steroids (Cortisone, etc.)?	Υ	N
F. Tranquilizers?	Υ	N
G. Insulin or Oral Anti-Diabetic Drugs?	Υ	N
H. Digitalis, Inderal, Nitroglycerin or other heart drug?      I. Are you taking or have you ever taken	Υ	N
Bisphosphonates (Fosamax or Actonel for osteoporosis or chemotherapy for multiple myeloma, etc.)?	Υ	N
J. Please list any and all medications taken inc	luding p rals	rescription medications, over-the-counter medications,
ARE YOU ALLERGIC TO OR HAVE YOU HAD		
AN ADVERSE REACTION TO:  A. Local Anesthesia (Novocain, etc.?)	Y	N
B. Penicillin or other Antibiotics?	Υ	N
C. Sedatives, Barbiturates?	Υ	N .
D. Aspirin or Ibuprofen?	Y	N
E. Codeine or other pain killers?	Υ	N
	Y	N
F. Latex or Rubber products?		N
G. Other allergies or reactions?	Υ	N - Company of the co
Please list: Do you smoke or chew tobacco?	Υ	N
Is there any past history of alcohol or chemical dependency/abuse?	Υ	N
Have you had any serious problems associated		
with any previous dental treatment?  Do you have any other disease, condition or	Υ	N
problem not listed above that you think the doctor should know about?		N
I understand the importance of a truthful Health Histo had the opportunity to discuss my Health History with	ry to ass h my do	sist the doctor in providing the best care possible. I have ctor.
Date Signature of Person Completing Healt	th History	Doctor's Initials
ormer Dentist		Phone
ate of Last Dental Exam and X-Rays:		Type of treatment:
ist any difficulties with past treatment:		
ist any difficulties with past treatment:  Chief oral complaint:		

Date

Patient