Littleton Implants & PERIODONTICS

HEALTH HISTORY

Patient Name _____ **Date of Birth** _____

Are you having pain or discomfort at this time?	☐Yes	☐No
Do you feel very nervous about having dental treatment?	☐Yes	☐No
Have you been a patient in the hospital during the past two years?	☐Yes	☐No
Have you been under the care of a medical doctor during the past two years?	☐Yes	☐No
Have you had any excessive bleeding requiring special treatment?	☐Yes	☐No
Is there anything you would like to change about your smile?	☐Yes	☐No
When was your last dental cleaning and exam?		
Name of general dentist:		
Name of primary care physician: Phone Number:		
Reason for today's visit:		

Please check any of the following that pertain to your past or present medical history:

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Heart Failure	☐ Mitral Valve Prolapse
☐ Allergies	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Heart Surgery	☐ Pain in Jaw Joints
☐ Anaphylaxis	☐ Cortisone/Steroids	☐ Hemophilia	☐ Radiation Treatments
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Renal Dialysis
☐ Angina	☐ Diabetes HbA1C _____	☐ Herpes	☐ Rheumatic Fever
☐ Anxiety	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Emphysema	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sinus Trouble
☐ Artificial Joints	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular heartbeat	☐ Stroke
☐ Bisphosphonate Medication	☐ Frequent Cough	☐ Kidney Problems	☐ Thyroid Disease
☐ Blood Thinner Medication	☐ Frequent Headaches	☐ Leukemia	☐ Tuberculosis
☐ Breathing Problems	☐ Glaucoma	☐ Liver Disease	☐ Tumors or Growths
☐ Bruise Easily	☐ Heart Attack	☐ Low Blood Pressure	☐ Ulcers
☐ Cancer	☐ Heart Disease	☐ Lung Disease	☐ Yellow Jaundice

Do you have any disease, conditions, or problems not listed? ☐Yes ☐No
If yes, please list:_____
_____

Please list any past surgeries and date of treatment:_____
_____

Do you require antibiotic pre-medication prior to dental procedures? ☐Yes ☐No

Please list all medications you are currently taking or provide a list:_____
_____

Have you ever taken Fosamax, Boniva, Actonel, Reclast or any other bisphosphonate medications? ☐Yes ☐No

Are you allergic to any medications? ☐Yes ☐No
☐ Aspirin ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Latex ☐ Ibuprofen ☐ Other _____

Do you use any of the following products? ☐Yes ☐No
☐ Cigarettes/e-cigarettes ☐ Alcohol ☐ Marijuana ☐ Other tobacco products ☐ Other controlled substances

Women:
Are you pregnant, trying to get pregnant, nursing or taking birth control pills? ☐Yes ☐No

Signature:_____ **Date:**_____

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