

HEALTH HISTORY



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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name _____ Date of Birth _____

Are you under a physician's care now? Yes No

If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No

If yes, please explain _____

Have you ever had a serious neck injury? Yes No

If yes, please explain _____

Are you taking any medication, pills or drugs? Yes No

If yes, please explain _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No **Do you use tobacco?** Yes No

Do you use controlled substances? Yes No

(Women) Are you pregnant or trying to get pregnant?: Yes No

Are you taking oral contraceptives?: Yes No **Are you nursing?:** Yes No

Are you allergic to any of the following?

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Rubbing Alcohol | <input type="checkbox"/> Bleach | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Other Medications |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Metals | <input type="checkbox"/> Fluoride | |

Please include any items not specified above _____

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Do you have, or have you had, any of the following? *(Please check all that apply)*

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells/
Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal
Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cold Sores/Fever
Blisters | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart
Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| | <input type="checkbox"/> Radiation Treatments | | |

Have you ever had any serious illness not listed above? Yes No

If yes, please explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or minor patient's) health. It is my responsibility to inform Green Valley Dental of any changes in my medical status.

Signature of Patient, Parent or Guardian _____

Health Information Update

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____