

PERSONAL HEALTH HISTORY

Primary Care Physician Name _____ Phone _____

1. Do you consider yourself in good health? Yes No
2. How long has it been since you have seen a dentist? _____ Dentist's name _____
3. Have you ever had any severe reaction to dental treatment or local anesthetics? Yes No
4. Have you ever taken Phen-Fen or similar appetite suppressants? Yes No
If yes, have you seen your physician or cardiologist for a cardiac evaluation? Yes No
5. Have you ever taken AREDIA, BONEFOS, DIDRONEL or ZOMETA for treatment of Breast/Prostate Cancer or Multiple Myeloma Yes No
6. Have you ever or are currently taking FOSAMAX, ACTONEL, or BONIVA for Osteoporosis or Paget's disease Yes No
6. Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Yes No		Yes No		Yes No	
Anemia	<input type="checkbox"/> <input type="checkbox"/>	Hay Fever	<input type="checkbox"/> <input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/>
Alcohol counseling	<input type="checkbox"/> <input type="checkbox"/>	Head Injuries	<input type="checkbox"/> <input type="checkbox"/>	Pacemakers	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>	Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>
Blood Disease	<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Rheumatism	<input type="checkbox"/> <input type="checkbox"/>
Blood Problems	<input type="checkbox"/> <input type="checkbox"/>	Heart Problems	<input type="checkbox"/> <input type="checkbox"/>	Sensitive Gums	<input type="checkbox"/> <input type="checkbox"/>
Bleed/Bruise Easily	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/> <input type="checkbox"/>	Seizures	<input type="checkbox"/> <input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Sinus Problems	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/>	Stomach Problems	<input type="checkbox"/> <input type="checkbox"/>
Circulation Problems	<input type="checkbox"/> <input type="checkbox"/>	Immune System Disorders	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/>
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disease	<input type="checkbox"/> <input type="checkbox"/>	TMD	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/>	Low blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Tumors	<input type="checkbox"/> <input type="checkbox"/>
Fainting/Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Mental Disorders	<input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> <input type="checkbox"/>
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/> <input type="checkbox"/>	Venereal Disease	<input type="checkbox"/> <input type="checkbox"/>
Growths	<input type="checkbox"/> <input type="checkbox"/>	Prescription Drug Counseling	<input type="checkbox"/> <input type="checkbox"/>	Other _____	

6. Have you ever had a joint replacement? Yes No If yes, what joint(s) and when _____
7. Do you require antibiotic pre-medication for heart conditions, artificial valves, or artificial joints? Yes No
8. Do you use tobacco products? Yes No
9. Do you like nitrous oxide (laughing gas)? Yes No Unsure
10. WOMEN: Are you Pregnant? Yes No Due date? _____
11. Do you have any other concerns? Yes No Specify _____

Medications

List any medications including birth control and herbal supplements:

Allergies

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local anesthetics |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Other _____ |

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT and CONSENT TO PROCEED

I hereby certify that the answers to the foregoing health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions and/or medications can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Francis, Dr. Hadley, Dr. Marshall and/or such associates or assistants as she/he may designate to perform those procedure as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crown, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedure to ensure safe removal.

I understand that need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature _____
(Patient, legal guardian or authorized agent of patient)

Date _____

Witness _____

Date _____