HEALTH HISTORY

Name: ______________________________ Height: __________ Weight: __________
(First) (M.I.) (Last)

Physician: ______________________________ Office Phone: __________________

Specialist (e.g. cardiologist): ______________________________ Office Phone: __________________

	NO	YES	
1. Are you under a physician's care?	☐	☐	**If yes, why:** ______________
2. Have you had a medical operation?	☐	☐	**If yes, what:** ______________
3. Do you take blood thinners?	☐	☐	**If yes, what:** ______________

4. Have you ever taken medications for osteoporosis, such as Fosamax, Boniva, and Actonel? ☐ **NO** ☐ **YES**

   If yes, when and for how long? ______________________________

5. List any medications (prescription & nonprescription) you are currently taking: ______________________________

____

____

6. Are you allergic to or have you had reactions to the following ***(please check Yes or No for each)***?

NO	YES		NO	YES		NO	YES	
☐	☐	Aspirin	☐	☐	Penicillin	☐	☐	Local Anesthetics (e.g. Novocaine)
☐	☐	Ibuprofen (Motrin/Advil)	☐	☐	Codeine	☐	☐	Sedatives (e.g., Valium, Halcion)
☐	☐	Tylenol	☐	☐	Iodine	☐	☐	Acrylic / Metal / Latex

Other Allergies ______________________________

7. Do you have, or have you ever had, any of the following ***(please check Yes or No for each)***?

NO	YES		NO	YES		NO	YES		NO	YES	
☐	☐	Heart infection	☐	☐	Cardiac pacemaker	☐	☐	Radiation therapy	☐	☐	Cancer
☐	☐	Artificial heart valve	☐	☐	Other Heart Problems	☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Congenital heart defect	☐	☐	Total Joint Replacement	☐	☐	Kidney disease	☐	☐	Anemia
☐	☐	Cardiac stent	☐	☐	Rheumatoid Arthritis	☐	☐	AIDS or HIV infection	☐	☐	Stroke
		If yes, when __________	☐	☐	Stomach troubles / ulcers	☐	☐	Hepatitis (A, B, or C?)	☐	☐	Asthma
☐	☐	Heart bypass	☐	☐	Bleed easily	☐	☐	Jaundice	☐	☐	Emphysema
		If yes, when __________	☐	☐	Epilepsy / seizures	☐	☐	Thyroid problem	☐	☐	Tuberculosis

List any other medical conditions: ______________________________

8. Are you required to pre-medicate with antibiotics before a dental appointment? ☐ NO ☐ YES

9. Women Only ***(please check Yes or No for each)***:

NO	YES		NO	YES		NO	YES	
☐	☐	Are you pregnant or think you might be?	☐	☐	Are you nursing?	☐	☐	Are you taking birth control pills?

Antibiotics may reduce the effectiveness of oral contraceptives. Women of childbearing age should use alternative Methods of contraception while undergoing antibiotic therapy and for the remainder of the cycle affected by antibiotic use.

I certify that I have read and understood the above information and have answered the questions accurately to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Rados or any of her staff responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medications change, I will inform Dr. Rados and her staff at the next appointment.

______________________________ __________

SIGNATURE OF PATIENT (OR PARENT IF MINOR) **DATE**

Reviewed by: Dr. Rados Date: __________ NOTES: