HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT NAME _____ DATE OF BIRTH _____

IF PATIENT IS A MINOR OR HAS A LEGAL GUARDIAN, RELATION OF INDIVIDUAL COMPLETING FORM TO PATIENT ABOVE AND NAME? _____

Name Relationship

Dental Information For the following questions, please circle (Y) for yes and (N) for no to the following questions.

Do your gums bleed when you brush or floss?	Y	N	Do you have earaches or neck pains?	Y	N
Are your teeth sensitive to hot, cold, sweets or pressure?	Y	N	Do you have clicking, popping or jaw pain?	Y	N
Does food or floss catch between your teeth?	Y	N	Do you wake up in the morning with headaches?	Y	N
Do you experience dry mouth?	Y	N	Do you clench or grind you teeth?	Y	N
Have you had any periodontal (gum) treatments?	Y	N	Do you or your spouse notice you snore at night?	Y	N
Have you ever had orthodontic (braces) treatment?	Y	N	Do you have Sleep Apnea?	Y	N
Have you had any problems associated with previous dental work?	Y	N	If you have Sleep Apnea, do you use a CPAP?	Y	N
If yes, please explain: _____			If you use a CPAP, have you noticed changes with your mouth?	Y	N
Do you wear a denture or partial?	Y	N	Do play any active sports?	Y	N
Have you ever whitened your teeth?	Y	N	Do you have sore or mouth ulcers?	Y	N
Do you use any tobacco products (smoke, chew, snuff)?	Y	N	Do you drink alcoholic beverages?	Y	N

Date of your last dental exam: _____ Date of your last dental x-rays: _____

What was done at your last visit: _____

What is the reason for your dental visit today? _____

Medical Information Please circle (Y) for YES or (N) for NO where indicated and complete all questions.

Are you under the care of a physician?	Y	N	Have you had a serious illness, operation or been hospitalized in the past 5 years?	Y	N
Physician's Name: _____			If yes, what was the reason? _____		
Physician's Phone: _____			Please list all medications including vitamins/supplements/herbal medications: _____		
Physician's Address: _____			_____		
What are you being treated for by physician? _____			_____		

Are you taking the following medications?

Alendronate (Fosamax®)	Y	N	**WOMEN ONLY**: Are you:		
Residronate (Actonel®)	Y	N	Pregnant?	Y	N
Aredia® or Zometa®	Y	N	If yes, number of weeks: _____		
Prolia®	Y	N			
Coumadin®	Y	N			
Heparin®	Y	N			
Eliquis®	Y	N			
Pradaxa®		Y	N		

PREMEDICATION: Do you require antibiotics before dental treatment for the following reasons:

Joint replacements (hips, knees, shoulders, etc…)	Y	N	Heart murmurs	Y	N
Mitral Valve Prolapse	Y	N	Artificial heart valves	Y	N
Rheumatic Fever	Y	N			

HEART CONDITION(S): Y N

Please list all of your heart related conditions: _____

DO YOU HAVE ANY OF THE FOLLOWING:

High blood pressure	Y	N	Anemia	Y	N
AIDS or HIV infection	Y	N	Arthritis	Y	N
Autoimmune disease(s)	Y	N	Asthma	Y	N
Bronchitis	Y	N	Emphysema	Y	N
Sinus troubles	Y	N	Tuberculosis	Y	N
Cancer/Chemotherapy/Radiation	Y	N	Diabetes Type I or II	Y	N
Gastrointestinal disease	Y	N	G.E. reflux/persistent heartburn	Y	N
Thyroid problems	Y	N	Stroke	Y	N
Hepatitis B or C	Y	N	Jaundice or liver disease	Y	N
Epilepsy	Y	N	Fainting episodes/seizures	Y	N
Neurological disorder(s)	Y	N			
Mental health disorder	Y	N	If yes, specify: _____		
Kidney problems	Y	N	Osteoporosis	Y	N
Sexually transmitted disease	Y	N	Alzheimer's disease	Y	N
Herpes virus	Y	N			

ALLERGIES: Are you allergic or have you ever experienced any reaction to the following? Circle (Y) for yes and (N) for no.

Local anesthetics	Y	N	Penicillin or other antibiotics	Y	N
Aspirin	Y	N	Barbiturates	Y	N
Sedatives	Y	N	Sulfa drugs	Y	N
Codeine	Y	N	Metals	Y	N
Latex (rubber)	Y	N			
Sleeping pills	Y	N			

ATTESTATION AND SIGNATURE

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication(s), I will inform River Valley Dental and the treating dentist(s) at the next appointment

Signature of Patient/Parent/Legal Guardian _____ *Date* _____

Print Name _____

Signature of Doctor _____ *Date* _____