

HEALTH HISTORY

Correct answers to the following questions will allow Dr. Renken to treat you on a more individual basis, providing the care appropriate for your particular needs. All information is completely confidential.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized or had a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 3. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 4. (Women) Are you pregnant/trying to get pregnant? If so, give due date _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco in any form? If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you ever had any of the following?

- | | YES | NO | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid condition/goiter | <input type="checkbox"/> | <input type="checkbox"/> | Stent with releasing medication* | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints/limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/tingling | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/fainting | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/trouble | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve* | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Stent | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> |

6. Are you ALLERGIC or have you ever experienced any reaction to the following?

- | | | | | | | | | |
|-------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Local anesthetics | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Other allergies _____ | | |
| Other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

7. Are you TAKING any of the following?

- | | | | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone/steroids | <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerine | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners (e.g., Plavix) | <input type="checkbox"/> | <input type="checkbox"/> | Insulin/other diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis drugs (e.g., Actonel, Fosamax, Boniva, Reclast) | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> | Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> | Other medication not listed here. | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis/other heart medications | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Antihistamines/allergy drugs/cold remedies | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

If yes to any of the above, list name of medication and dosage below:

1. _____
2. _____
3. _____
4. _____

8. Physician's Name _____ Phone _____

9. Have you ever had any serious trouble associated with previous dental treatment? _____

10. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

11. Date of last dental visit _____

12. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

 If so, when? _____

13. Do you wish to talk with the dentist privately about any problem or concern? _____

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I understand that the information I have given today is correct to the best of my knowledge. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status at the next appointment.

Signature of Patient (Parent or Guardian) _____ Date _____

Doctor's Signature _____ Date _____