HEALTH HISTORY **STEVEN H. DAVIS, D.D.S., P.A.**

Today's Date:				
Name:	**DOB:**	**Age:**	**Height:**	**Weight:**

Why are you seeking treatment? _____

Referred by: _____

Although we 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 care that you will be receiving.

Please answer each question. Check yes or no. If in doubt, leave blank.	**YES**	**NO**
1. Are you in good health now?		
2. Are you under the care of a physician? If so, for what are you being treated? _____ Date of last visit: _____		
3. Have you ever been hospitalized or had a serious illness? If yes, explain: _____		
4. Do you have a prosthetic joint/implant? If so, describe where: _____		
5. Have you ever had a heart valve replacement or vascular graft? If so, when: _____		
6. Do you use tobacco in any form? If yes, how much? _____		
7. Do you use alcoholic beverages (more than 2 drinks per day)?		

8. Have you had or do you currently have any of the following:

	YES	**NO**
GENERAL:		
Tire easily, weakness		
Marked weight change		
Night sweats		
Persistent fever		
SKIN:		
Eruptions, rash, hives		
Skin color changes		
Lumps, purple/blue spots		
EYES:		
Visual change		
Glaucoma		
EARS:		
Loss of hearing		
Ringing in the ears		
NOSE:		
Frequent nosebleeds		
Sinus problems		
NERVOUS SYSTEM:		
Stroke		
Headaches		
Convulsions/epilepsy		
Dizziness/fainting		
Psychiatric treatment		
ENDOCRINE:		
Diabetes		
Family history of diabetes		
Thyroid condition/goiter		

	YES	**NO**
RESPIRATORY:		
Asthma		
Hayfever		
Tuberculosis		
Emphysema		
Chronic bronchitis		
Persistent cough		
Sputum production (phlegm)		
Cough up bloody sputum		
Difficulty breathing lying down		
Other lung disease:		
HEART/BLOOD VESSELS:		
Rheumatic fever		
Heart murmur		
Irregular heart beat		
Chest pain/angina		
Heart attack/disease/trouble		
Shortness of breath		
Swelling of ankles		
High blood pressure		
Low blood pressure		
Congenital heart disease		
Mitral valve prolapse		
Artificial heart valve		
Pacemaker		
Heart surgery		
Other heart disease: (explain)		

	YES	NO
DIGESTIVE SYSTEM:		
Hepatitis		
Jaundice		
Ulcers		
Change in appetite		
Black, bloody or pale stools		
BLOOD:		
Bruise easily		
Anemia		
Blood transfusion		
Bleeding disorder		

	YES	NO
BONE/MUSCLE:		
Arthritis/rheumatism		
Artificial joints/limbs		
URINARY SYSTEM:		
Kidney disease		
Increase in urination frequency		
Burning on urination		
Urethral discharge		
Bloody urine		
Are you on dialysis		
Sexually transmitted diseases		

OTHER:

	YES	NO
Radiation therapy		
Chemotherapy		
Cancer, tumors or goiters		

	YES	NO
Problems with immune system		
HIV + or AIDS		
Malignant hyperthermia		

WOMEN:

	YES	NO
Possibility of pregnancy		
Estimated delivery date:		

	YES	NO
Are you nursing		
Are you taking birth control pills or other hormone therapy		

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.

9. Are you taking any of the following **MEDICATIONS:**

	YES	NO
Antibiotics/sulfa drugs		
Blood thinners/anticoagulants		
Blood pressure medication		
Thyroid medication		
Cortisone/steroids		
Antihistamines/allergy drugs		
Bisphosphonates: Aredia, Boniva, Zometa, Actonel, Fosamax		
Reclast (Zoledronic acid) IV		

	YES	NO
Tranquilizers/sedatives		
Insulin/other diabetic drugs		
Recreational drugs		
Digitalis/other heart medicines		
Nitroglycerin		
Aspirin		
Diet pills:Fen-Phen, Redux, Pondimin		
Heart valve disease related to diet pill use?		

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

10. Are you **ALLERGIC** to, or have you experienced any reaction to the following medications:

	YES	NO
Local anesthetic (Novocain)		
Barbiturates/sedatives		
Aspirin		
Eggs/other foods		
Penicillin		

	YES	NO
Sulfa drugs		
Iodine		
Codeine		
Other narcotics:		

Other antibiotics:

1. _____
2. _____

Other allergies:

1. _____
2. _____

11. Is there any disease, condition, or problem not listed above that you think we should know about, or is there any activity your doctor says that you cannot do? **YES / NO** If so, explain: _____

Physician's name: _____ Phone: _____

12. Have you or anyone in your family ever had any problem with previous surgery or anesthesia? **YES / NO**
If yes, please explain: _____

13. How nervous are you about oral surgery? Not: _____ Slightly: _____ Moderately: _____ Extremely: _____

14. Do you have, or have you ever had any of the following:

	YES	NO
MOUTH:		
Periodontal disease, pyorrhea		
Bleeding, sore gums		
Unpleasant taste/bad breath		
Burning tongue/lips		
Numbness face/lips/tongue		
Purple or blue spots		
Orthodontic treatment (braces)		
Biting cheeks / lips		
Clicking/popping jaw		
Difficulty opening/closing jaw		
Temporomandibular disorder		

	YES	NO
TEETH:		
Loose teeth		
Sensitive to hot		
Sensitive to cold		
Sensitive to sweets		
Sensitive to biting		
Food impaction		
Clenching/grinding		
Shifting teeth/change in bite		
Fractured/broken teeth		
Fractured/broken fillings		
Excessive bleeding from extractions		

To the best of my knowledge, all of the preceding answers are true and correct. I will not hold my doctor or staff responsible for any errors or omissions that I might have made in completing this form. If I ever have any change in my health or medications, I will inform the doctor at the next appointment.

Signature of patient/parent: _____ Date: _____

Relationship to patient: _____

Doctor initial: _____ Date: _____

HEALTH HISTORY UPDATED:

Signature of patient/parent: _____ Date: _____
Relationship to patient: _____ Date: _____
Doctor initial: _____ Date: _____

Signature of patient/parent: _____ Date: _____
Relationship to patient: _____ Date: _____
Doctor initial: _____ Date: _____

Signature of patient/parent: _____ Date: _____
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