Scottsdale Smile Center | General, Restorative & Cosmetic Dentistry
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HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

List names and phone numbers of physicians currently providing you care.

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

List all medications you are currently taking, including OTC and supplements.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Allergies - are you allergic to or have you had unfavorable reaction to any of the following?

Penicillin or other antibiotics	No	Yes	Latex	No	Yes
Codeine	No	Yes	Metals	No	Yes
Valium or other sedatives	No	Yes	Local Anesthetics	No	Yes
Aspirin, Tylenol or Ibuprofen	No	Yes	Other (specify) _____		

Tobacco, Alcohol, Drugs

Do you use tobacco?	No	Yes	Smoke?	No	Yes	how long? _____
Do you want to quit?	No	Yes	Chew?	No	Yes	how long? _____
Do you consume alcohol?	No	Yes	How much/often? _____			
Do you use any mood altering drugs? (list) _____						

Do you take any of these medications?

Pre-medication before dental treatment	No	Yes	Bisphosphonates - Fosamax, Zometa, Actonel, Reclast	No	Yes
Antacids	No	Yes	Dilantin or Tegretol	No	Yes
St John's Wort or Kava-Kava?	No	Yes	Tagament or Prilosec?	No	Yes

Blood Pressure

Do you have high blood pressure?	No	Yes	BP today _____		

Do you have now or a history of?

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Fainting or Dizzy Spell	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes
			Women - Are you pregnant?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient (Print Name) _____ Patient Signature _____ Date _____

Doctor (Print Name) _____ Doctor Signature _____ Date _____