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

Name ______________________________ DOB: ______________________________

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 ________