



DC Perio & Implants
PLLC

Health History Form

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex:

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer/School _____ Work Phone _____

Cell Phone _____ Occupation _____

Email Address _____ Emergency Contact _____

Whom may we thank for referring you? _____

Name of Insured _____ Relationship to Patient _____

Subscriber's Birthdate _____ Insurance ID No# _____

Name of Employer _____ Work Phone _____

Name of Dental Insurance Co. _____ Group No. _____

Ins. Co. Address _____ City _____ State _____ Zip code _____

All information provided here is **confidential** and any attempt to conceal pre-existing conditions or other relevant information may result in serious drug interactions or death. For the following questions, **choose Yes or No**:

1. Are You in Good Health?
2. Has There Been Any Change in Your General Health Within the Past Year?
3. My Last Physical Exam Was On: _____
4. Are You Now Under the Care of a Physician?
If Yes, For What Condition? _____
5. Your Physician's Name: _____
Your Physician's Phone #: _____
6. Do You Smoke?
If So, How Many Packs/Day _____ Years _____
Do you use e-cigs or Vape
7. Have You Had Any Serious Illness, Operation, or Been Hospitalized in The Past 5 Years
8. Are You Taking Any Medicine(s), Including Non-Prescription Medicines?
9. Have You Ever Taken ☐ Alendronate (Fosamax), ☐ Risedronate (Actonel), ☐ Ibandronate (Boniva), ☐ Zoledronate (Reclast), ☐ Pamidronate (Aredia), ☐ Denosumab (Prolia), ☐ Bevacizumab (Avastin), ☐ Sunitinib (Sutent) (**circle which one**)?
10. Do You Have or Have You Had Any of The Following Diseases?
 - a. ☐ Damaged or ☐ Artificial Heart Valves, ☐ Heart Murmur, or ☐ Rheumatic Heart Disease (**circle which one**)
 - b. Artificial Joints or Prostheses
If Yes, Where? _____
 - c. ☐ Cardiovascular Disease, ☐ Angina, ☐ Heart Attack, ☐ Heart Trouble, ☐ Coronary Bypass Operation, ☐ Stroke (**circle which one**)
 - d. Do You Have A Pacemaker?
 - e. High Blood Pressure
 - f. High Cholesterol
 - g. Diabetes (Blood Sugar Problems)
 - h. Osteoporosis
 - i. ☐ Tumor or ☐ Cancer Requiring ☐ Surgery, ☐ Radiation or ☐ Chemotherapy (**circle which one**)

- j. ☐ Fainting Spells, ☐ Seizures or ☐ Epilepsy (**circle which one**)
- k. ☐ Phobias, ☐ Severe Anxiety, ☐ Depression (**circle which one**)
- l. Thyroid Problems
- m. Sinus Problems
- n. ☐ Ear or ☐ Hearing Problems (**circle which one**)
- o. ☐ Arthritis, ☐ Rheumatism (**circle which one**)
- p. Kidney Disease
- q. ☐ Hepatitis, ☐ Jaundice or ☐ Liver disease (**circle which one**)
- r. AIDS or HIV Infection
- s. Tuberculosis (TB)
- t. Sexually Transmitted Disease
- u. Sleep Apnea
- v. ☐ Asthma or ☐ Emphysema (**circle which one**)
- w. ☐ Respiratory Problems, ☐ Bronchitis (**circle which one**)
- x. ☐ Stomach Ulcer, ☐ Hyperacidity, ☐ GERD (**circle which one**)
- y. Cortisone Treatment
- z. Glaucoma
11. Have You Had Abnormal Bleeding?
or Required A Blood Transfusion?
12. Do You Have Any Blood Disorder Such as Anemia?
13. Are You Allergic or Have You Had A Reaction To:
- a. Dental Anesthetics
- b. ☐ Penicillin or ☐ Other Antibiotics (**circle which one**)
- c. Sulfa Drugs
- d. Barbiturates, Sedatives or Sleeping Pills
- e. Aspirin
- f. Iodine
- g. ☐ Codeine or ☐ Other Narcotics (**circle which one**)
- h. Latex
- i. Other _____
14. Have You or A Close Relative Ever Had an Anesthesia Complication?
Or a Bad Reaction to Anesthetic Drugs?

Women

15. Are You Pregnant?
16. Are You Nursing?
17. Are You Taking Birth Control Pills?

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and/or dental status to my periodontist at the earliest possible time. I give permission to my periodontist to obtain any additional information from my physician regarding my medical history.

Patient's Signature (or patient's guardian)

Date

Dentist Signature

Date

Medication List

Patient Name: _____

Date: _____

[illegible]