

Dental Implant and Periodontal Health of Rochester
1815 South Clinton Ave Suite 510 Rochester, NY Office: 585-685-2005 Fax: 585-685-2003

Health History

Name _____ Date _____

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

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the dentists and physicians who are providing care for you:

1. General Dentist: _____
2. Primary Care MD: _____
3. Specialist MD: _____

For the following questions, please circle yes or no. Your answers are for our records only and will be confidential. Please note that our team may ask additional questions concerning your health in order to optimize your care.

Anemia or Blood Disorder	No	Yes	Hepatitis, any form	No	Yes
Diabetes—Type I or Type II Last HbA ₁ C- date _____ value _____	No	Yes	Liver disease	No	Yes
Asthma Been hospitalized for condition?	No	Yes	Joint replacement- what joint _____ When placed?	No	Yes
COPD or other lung disease Do you use a Bi-PAP or CPAP?	No	Yes	HIV infection / AIDS or ARC	No	Yes
Abnormal bleeding	No	Yes	Kidney disease	No	Yes
Epilepsy, Seizure, fainting spells	No	Yes	Psychiatric Care	No	Yes
Abnormal Heart Beat	No	Yes	Stroke	No	Yes
Heart disease, Heart attack, and/or Heart surgery	No	Yes	Cancer or tumor Radiation or Chemotherapy	No	Yes
Heart stent when placed?	No	Yes	Glaucoma	No	Yes
Heart murmur, heart valve disease	No	Yes	Rheumatic fever	No	Yes
Heart and/or valve replacement	No	Yes	Recurrent sinus infections	No	Yes
Previous Bacterial Endocarditis	No	Yes	Slow healing mouth sores	No	Yes
Arthritis, Rheumatism, Inflammatory disease	No	Yes	High Blood Pressure	No	Yes

Abnormal Blood Pressure? (please circle) No Yes What is your normal blood pressure?: _____
 Today (in office): BP _____ HR _____

Are you taking any of these medications?

Pre-medication prior to dental treatment?	No	Yes	Aspirin	No	Yes
Barbiturates	No	Yes	Vitamin E	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Flax, Fish or Krill Oil	No	Yes
Have you ever been treated with Bisphosphonate medication: (Fosomax, Didrolel, Aclast, Atelvia, Skelid, Aredia, Zometa, Actonel, Boniva, Reclast, Xgeva, Prolia, Denosudum) ? If so when did treatment begin? _____ When did treatment end? _____				No	Yes
Antiquagulants: (Warfarin ,Coumadin,Rivaroxaban ,Xarel,, Dabigatran ,Pradaxa, Apixaban, Eliquis, Edoxaban, Savaysa, Enoxaparin, Lovenox, Fondaparinux, Arixtra, Brilinta, Plavix) ?				No	Yes
Immunosuppressants (Humira, Remacade, Enbrel) ?				No	Yes

Medications

Please list any medications (prescription and over-the-counter) you are currently taking; include any medication patches and medications for smoking cessation:

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

Please list any dietary or herbal supplements you are taking and for what purpose:

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

Allergies/Adverse Reactions

Are you allergic or have you had a reaction to:

	No	Yes	<u>Type of Reaction</u>
a. Latex or Metals	No	Yes	_____
b. Antibiotics	No	Yes	_____
which? (please circle) Penicillin;.. Sulfa; Erythromycin; Tetracycline,			
other _____			_____
c. Aspirin, Ibuprofen, Tylenol	No	Yes	_____
d. Local anesthetics, including topical	No	Yes	_____
e. Codeine, Valium, or other sedatives	No	Yes	_____
f. Sulfites or preservatives	No	Yes	_____
g. Other _____			_____

Women:

- a. Are you pregnant? No Yes
- b. Are you a nursing mother? No Yes
- c. Menopause? No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes circle type: smoke chew vape patch lozenge gum How much per day? For how many years?	No	Yes
Do you want to quit using tobacco?	No	Yes
Have you used or smoked tobacco in the past? How much? For how many years?	No	Yes
Do you consume alcohol? If yes, approximately how many drinks per week?	No	Yes
Do you use any mood altering drugs other than those listed previously	No	Yes

Is there anything else we should know about your health that was not covered by this questionnaire? _____

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.

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date