HEALTH HISTORY

Andrew Wappett D.M.D. P.C. FAMILY DENTISTRY

PLEASE FILL IN THE FOLLOWING INFORMATION.

MEDICAL DOCTOR _____ LAST PHYSICAL EXAM _____

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? ☐ YES ☐ NO

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN OVER THE LAST 2 MONTHS. (INCLUDING PRESCRIPTIONS, SUPPLEMENTS AND OVER THE COUNTER MEDICINES. _____

_____

_____

DO YOU HAVE ANY CONCERNS ABOUT RECEIVING DENTAL TREATMENT? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY _____

YES	NO	
☐	☐	DO YOU HAVE A TOOTHACHE NOW?
☐	☐	ARE YOU ALLERGIC TO ANY MEDICATIONS?

_____

_____

YES	NO	DO YOU HAVE A MEDICAL HISTORY OF:
☐	☐	DIABETES?
☐	☐	HIGH BLOOD PRESSURE?
☐	☐	HEART SURGERY?
☐	☐	HEART VALVE OR PACEMAKER?
☐	☐	HEART INFECTION? (INFECTIVE ENDOCARDITIS)
☐	☐	HEART ATTACK

SPECIFY ANY HEART RELATED PROBLEMS

_____

☐	☐	ARTIFICIAL JOINT? _____
☐	☐	HAVE YOU EVER, OR DO YOU NOW TAKE BISPHOSPHONATE MEDICATIONS? FOSAMAX, BONIVA, ACTONEL, ZOMETA, DIDRONEL, AREDIA, SKELID
☐	☐	MEDICAL CARE IN THE LAST 2 YEARS?
☐	☐	HOSPITALIZATIONS? IF SO, WHY? _____
☐	☐	BLEEDING PROBLEMS THAT NEEDED MEDICAL TREATMENT? WHAT?

_____

YES	NO	
☐	☐	DO YOU USE TOBACCO?
☐	☐	DO YOU DRINK ALCOHOL?
☐	☐	DO YOU USE OTHER DRUGS?
☐	☐	ASTHMA?
☐	☐	ANEMIA?
☐	☐	ARTHRITIS/RHEUMATISM?
☐	☐	CHEST PAINS?
☐	☐	CANCER OR TUMORS?
☐	☐	EPILEPSY OR SEIZURES?
☐	☐	HEPATITIS/LIVER PROBLEMS?
☐	☐	KIDNEY PROBLEMS?
☐	☐	LUPUS?
☐	☐	NERVOUS OR MENTAL DISORDERS?
☐	☐	SINUS TROUBLE?
☐	☐	STROKE?
☐	☐	TUBERCULOSIS OR LUNG DISEASE?
☐	☐	ULCERS?
☐	☐	DO YOU HAVE REASON TO BELIEVE YOU HAVE BEEN EXPOSED TO AIDS OR HIV?
☐	☐	DO YOU HAVE ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED? IF SO, WHAT?

_____

FEMALES ONLY

YES	NO	ARE YOU CURRENTLY:
☐	☐	PREGNANT?
☐	☐	TAKING BIRTH CONTROL PILLS?
☐	☐	NURSING?

AS OF (TODAY'S DATE) _____ THE INFORMATION I HAVE PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE INDICATES THAT I GIVE MY CONSENT FOR ROUTINE DENTAL PROCEDURES, SUCH AS X-RAYS, CLEANINGS, FILLINGS, CROWNS, AND LOCAL ANESTHESIA.

_____ _____

PATIENT OR PARENT/GUARDIAN DR. WAPPETT

_____ _____

PATIENT NAME DATE OF BIRTH