LOS ALTOS CORE DENTAL

Confidential Health History Form Today's Date:_______________________

Patient's Name:____ Date of Birth: ______________________

(First MI Last)

I. CIRCLE APPROPRIATE ANSWER. (Leave blank if you don't understand the question)

1. Yes/No Is your general health good?
   If NO, explain: ____
2. Yes/No Are you being treated by a physician now?
   If YES, explain: ____
   Date of last medical exam: _____________Reason for exam: ________________________________
3. Yes/No Have you had problems with prior treatment?
   If YES, explain: ____
   Date of last medical exam: _____________ Name of last treating dentist: ___________________________
4. Yes/No Have you ever been pre medicated before a dental visit?
   If Yes, Please explain: ____
5. Yes/No Are you in pain now?
   If YES, explain: ____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No AIDS/HIV
Yes/No Alzheimer's Disease
Yes/No Anaphylaxis
Yes/No Anemia
Yes/No Angina
Yes/No Arthritis/Gout
Yes/No Artificial Heart Valve
Yes/No Artificial Joint/Hip
Yes/No Asthma
Yes/No Blood Disease
Yes/No Blood Transfusion
Yes/No Breathing Problems
Yes/No Bruise Easily
Yes/No Cancer
Yes/No Chemotherapy
Yes/No Chest Pains
Yes/No Cold Sores
Yes/No Congenital Heart Disorder
Yes/No Convulsions
Yes/No Cortisone Medicine
Yes/No Diabetes
Yes/No Drug Addiction
Yes/No Easily Winded
Yes/No Emphysema
Yes/No Epilepsy or Seizures
Yes/No Excessive Bleeding
Yes/No Excessive Thirst
Yes/No Fainting Spells/Dizziness
Yes/No Frequent Cough
Yes/No Frequent Diarrhea
Yes/No Frequent Headaches
Yes/No Genital Herpes
Yes/No Glaucoma
Yes/No Hay Fever
Yes/No Heart Attack/Failure
Yes/No Heart Murmur
Yes/No Heart Pace Maker
Yes/No Heart Disease
Yes/No Hemophilia
Yes/No Hepatitis A
Yes/No Hepatitis B
Yes/No Hepatitis C
Yes/No Herpes
Yes/No High Blood Pressure
Yes/No Hives or Rash
Yes/No Hypoglycemia
Yes/No Irregular Heart Beat
Yes/No Kidney Problems
Yes/No Leukemia
Yes/No Low Blood Pressure
Yes/No Lung Disease
Yes/No Mitral Valve Prolapse
Yes/No Pain in jaw joints
Yes/No Parathyroid Disease
Yes/No Psychiatric Care
Yes/No Radiation Treatment
Yes/No Recent Weight Loss
Yes/No Renal Dialysis
Yes/No Rheumatic Fever
Yes/No Rheumatism
Yes/No Scarlet Fever
Yes/No Shingles
Yes/No Sickle Cell Disease
Yes/No Sinus Trouble
Yes/No Spina Bifida
Yes/No Stomach/Intestinal Disease
Yes/No Stroke
Yes/No Swelling of Limbs
Yes/No Thyroid Disease
Yes/No Tonsillitis
Yes/No Tuberculosis
Yes/No Tumors or Growths
Yes/No Ulcers
Yes/No Venereal Disease
Yes/No Yellow Jaundice

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III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No Aspirin
Yes/No Codeine
Yes/No Iodine
Yes/No Latex
Yes/No Penicillin or other antibiotics
Yes/No Sulfa Drugs
Yes/No Nitrous Oxide
Yes/No Valium or other sedatives
Yes/No Local anesthetic
Yes/No Food
Yes/No Metal

Others____________________

IV. PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

V.ALL PATIENTS (please circle yes or no for each)

Yes/No Do you have or have you had any medical conditions or allergies NOT listed on this form?
If YES, please explain: ______________________________

Yes/No Have you ever taken bisphosphonate medication (Fosamax, Actonel, Zometa, etc.)?
If YES,when?: ______________________________

Yes/No Have you ever taken FenNPhen or Redux?
If YES, when?: ______________________________

Yes/No Do you have history of alcoholism or drug addiction?
If YES, please explain:______________________________

Yes/No ***Is there any issue or condition that you would like to discuss with the dentist in private?***

VI. WOMEN ONLY (Please circle yes or no for each)

Yes/No Are you or could you be pregnant?
If YES, what month?: __________________

Yes/No Are you nursing?

Yes/No Are you taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian): ______________________________ Date: ________________

Signature of Dentist: ______________________________Date: ________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

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Thank you for taking the time to answer the above questions. ☺

Dentist Comments:______________________________
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MEDICAL HISTORY UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	***PATIENT SIGNATURE***	***CHANGES TO HEALTH HISTORY***	***DENTIST/STAFF INITIALS***
__________	________________	________________________	_____________________
__________	________________	________________________	_____________________
__________	________________	________________________	_____________________