HEALTH HISTORY

Name:______________________________ **Date:**______________________

Address:______________________ **City**______________ **State**________ **Zip** ______________

Phone numbers: Home:__________________ **Work:**__________________ **Cell:** __________________

Email:______________________ **Marital Status: Married**________ **Single**________ **Divorced**________ **Other** ________

Male________ **Female**________ **Date of Birth**__________ **Age**________ **Social Security #** (for insurance purposes only) ______________

HOW CAN WE HELP YOU TODAY? ______________________________

ARE YOU A SEASONAL RESIDENT? ______ **YES** ______ **NO**

How did you learn about our office: *(Please check one)*
(__) Friend or Relative:__________________ **Star Banner (__) Yellow Pages(__) On Top of The World (__)Oak Run Newsletter(__)**

Driving by office/Truck (__) Website (__) Online Ad (__) Flyer in mail (__) Internet search (Google/Bing)__ __________Other:________

Date of last health care exam:______________ **Date of last Dental Exam:**______________ **Last Dental Cleaning:** ______________
Name, location, phone number for Preferred Pharmacy:______________________________

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

1. Artificial heart valve	No	Yes	Heart attack (MI) (When)__________	No	Yes
2. History of infective endocarditis	No	Yes	Hypertension	No	Yes
3. Congenital heart conditions (birth defects):	No	Yes	Low blood pressure	No	Yes
repaired or incompletely repaired cyanotic			Pacemaker (What Kind) __________	No	Yes
disease, prosthetic repair, remaining defect			Heart stent (When) __________	No	Yes
after repair			Heart Bypass (When) __________	No	Yes
4. Cardiac transplant with heart valve problem	No	Yes	Stroke: (When) __________	No	Yes
History of prolonged use of Morphine	No	Yes	Treated for Anxiety	No	Yes
Treated for Chronic Pain Management	No	Yes	Treated for Depression	No	Yes
History of recreational drug use (Confidential)	No	Yes	Treated for Psychosis	No	Yes
Organ Transplant (When)__________	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Asthma	No	Yes	Latex Allergy	No	Yes
Diabetes	No	Yes	Joint Replacement (When?) (What kind?)	No	Yes
Hepatitis, Any Form	No	Yes	Previous Biopsies	No	Yes
Liver disease (including Jaundice)	No	Yes	Slow-Healing Mouth Sores	No	Yes
Kidney disease	No	Yes	Abnormal Bleeding from a cut	No	Yes
Anemia (blood disease)	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Sinus trouble	No	Yes
Epilepsy	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Recurrent Illnesses	No	Yes
Venereal Disease	No	Yes	Other Infections:	No	Yes
History of surgeries __________	No	Yes	Cancer/ Tumors __________	No	Yes
G.E.R.D. or Gastric Reflux or Ulcers	No	Yes	Radiation or Chemotherapy	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal Supplements?	No	Yes
Anticoagulants ? Blood Thinner Name:__________	No	Yes	Daily Aspirin? 81mg 325mg	No	Yes
Have you been treated with Bisphosphonate drugs? Fosamax, Boniva or Actonel				No	Yes

Please list any medications or supplements you are currently taking?

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________

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 physicians who are currently providing you care:

1. ______________________________ **2.** ______________________________

3. ______________________________ **4.** ______________________________

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually? S________ /D________

Are you allergic or have you had a reaction to any of the following. Please circle and/or specify:

- **a.** Local anesthetics .... No Yes
- **b.** Penicillin or other antibiotics .... No Yes
- **c.** Aspirin .... No Yes
- **d.** Codeine, valium or other sedatives .... No Yes
- **e.** Other ______________________________ No Yes

Are you a smoker? No Yes

If so, how much do you smoke per day? ______________________________

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Average Weight: ______________________________

Diet: Restricted Diet: ______________________________ **How many meals a day?** ______________________________ **Food Allergies:** ______________________________ **Sugar in your diet:** O None O Slight O Moderate O High

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 changes in my health and medication.

______________________________ ______________________________ ______________________________

Patient (Print Name) *Patient Signature* *Date*

Susana Hernandez DMD

______________________________ ______________________________ ______________________________

Dentist (Print Name) *Dentist Signature* *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

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____ ____________________

Employee signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.