Timothy A. Hess, DDS, MAGD
COMPREHENSIVE DENTAL CARE

Health History

Reset Form | Print Form

Name: _____ Date: _____

Do you have or have you had any of the following? Please check "YES" or "NO".

Heart Problems:

- High or Low Blood Pressure..... ◯ YES ◯ NO
- Heart Murmur or Mitral Valve Prolapse..... ◯ YES ◯ NO
- Artificial Valve, Pacemaker or Stent..... ◯ YES ◯ NO
- Arteriosclerosis..... ◯ YES ◯ NO
- Heart Attack or Angina Pectoris..... ◯ YES ◯ NO
- Heart Medications or Nitroglycerin..... ◯ YES ◯ NO

Blood Problems:

- Easy Bruising..... ◯ YES ◯ NO
- Abnormal Bleeding..... ◯ YES ◯ NO
- Blood Thinners(Coumadin, Plavix or Aspirin).. ◯ YES ◯ NO
- Circulatory Problems..... ◯ YES ◯ NO
- Hemophilia..... ◯ YES ◯ NO
- Low Blood Sugar or Anemia..... ◯ YES ◯ NO

Respiratory Problems:

- Asthma, Emphysema or Tuberculosis..... ◯ YES ◯ NO
- Tuberculosis..... ◯ YES ◯ NO
- Chronic Bronchitis..... ◯ YES ◯ NO

Sinus Troubles..... ◯ YES ◯ NO

Frequent or Severe Headaches..... ◯ YES ◯ NO

Fainting Spells, Seizures or Epilepsy..... ◯ YES ◯ NO

Bone or Joint Problems

- Joint Replacement (Hip, Pins, Plates, etc)..... ◯ YES ◯ NO
- Implants..... ◯ YES ◯ NO
- Arthritis or Osteoporosis..... ◯ YES ◯ NO
- Taking Bisphosphonates (Fosamax, Boniva)... ◯ YES ◯ NO
- Taking Corticosteroids..... ◯ YES ◯ NO

Cancer (Chemotherapy or Radiation)..... ◯ YES ◯ NO

Tumours or Benign Growths..... ◯ YES ◯ NO

Allergic Reactions:

- Aspirin, Acetaminophen, or Ibuprofen..... ◯ YES ◯ NO
- Codeine or Other Narcotics..... ◯ YES ◯ NO
- Dental Anesthetic..... ◯ YES ◯ NO
- Sensitivity to Epinephrine (Vasoconstrictor)... ◯ YES ◯ NO
- Antibiotics (Penicillin or Other)..... ◯ YES ◯ NO
- Sedatives(Valium) or Sleeping Pills..... ◯ YES ◯ NO
- Latex (Allergy or Sensitivity)..... ◯ YES ◯ NO

Other: _____

Diabetes..... ◯ YES ◯ NO

Any Physical Limitations..... ◯ YES ◯ NO

Hearing or Sight Disability..... ◯ YES ◯ NO

Glaucoma or Contact Lenses..... ◯ YES ◯ NO

Psychiatric Treatment ..... ◯ YES ◯ NO

Depression or Anxiety Disorder..... ◯ YES ◯ NO

HIV or Aids..... ◯ YES ◯ NO

Hepatitis A, B or C..... ◯ YES ◯ NO

Liver or Kidney Issues..... ◯ YES ◯ NO

Drug or Alcohol Abuse Issues..... ◯ YES ◯ NO

Smoke or Chew Tobacco..... ◯ YES ◯ NO

Women

- Are you pregnant?..... ◯ YES ◯ NO
- Taking Hormones or Contraception?..... ◯ YES ◯ NO

Do you require "Premedication" with an antibiotic prior to dental treatment?..... ◯ YES ◯ NO

Snoring..... ◯ YES ◯ NO

Sleep Apnea/ CPAP..... ◯ YES ◯ NO

GERD/Acid Reflux..... ◯ YES ◯ NO

Any Medications or Health Issues we should know about?:

(Reviewers Sign and Date)

Name of Patient, Parent or Guardian: _____ Signature: _____