DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

HEALTH HISTORY FORM

Name ________________________________

Address ________________________________

City ______________________ State ______

Social Security Number ______-____-_______

Height: _______ Weight: _______

Referring Dentist _______________________

DATE: ____________________________

Home Phone ______________________

Work Phone ______________________

Zip Code ______________________

Date of Birth ______________ Sex M F

Single: ____ Married: ____

Name of Spouse ______________________

PLEASE CIRCLE YES (Y) OR NO (N) FOR THE FOLLOWING QUESTIONS

1. Are you in good health? Y N
2. Your last physical exam _________
3 Your primary doctor ____________
4. Rheumatic fever? Y N
5. Heart murmur? Y N
6. Mitral valve prolapse? Y N
7. Congenital heart disease? Y N
8. Prosthetic heart valves Y N
9. Pacemaker/stents Y N
10. Heart attack or angina Y N
11. High blood pressure Y N
12. Chest pain Y N
13. Asthma Y N
14. Emphysema Y N
15 Bronchitis Y N
16. Tuberculosis Y N
17. Shortness of breath Y N
18. Seizures/Epilepsy Y N
19. Fainting Y N
20. Mental health/anxiety Y N
21. Depression Y N
22. Sinus problems Y N
23. Cold sores(herpes) Y N
24. Dizziness Y N
25. Stroke Y N
26. Glaucoma Y N
27. Diabetes Y N
28. Kidney disease Y N
29. Thyroid disease Y N
30. Liver disease Y N
31. Jaundice Y N
32. Hepatitis type__ Y N
33. Cancer Y N
34. Radiation treatment Y N
35. Chemotherapy Y N
36. Bleeding disorder Y N
    type:_____________________

Please list your current medications including aspirin.

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____
____
____
____

Please list any surgeries including heart valve, joint replacement and kidney dialysis.

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____
____

Have you ever taken any medication for osteoporosis i.e. boniva, actenol, fossamax OR reclast?

____

Are you allergic to any medications, latex or food? ___________________

____
____

Do you require premedication with antibiotics prior to dental treatment?

____

Do you smoke? Y N

Do you drink alcohol? Y N

Do you use street drugs? Y N

Are you pregnant? Y N

Do you have any other disease or condition not listed? Y N

____
Patient's (or Legal Guardian's) Signature & Date

____
Reviewing Doctor's Signature & Date