WOOLSEY
FAMILY DENTAL

PATIENT'S NAME: _____ **DATE:** _____

Current Physician_____

Previous Dentist_____

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? **Y N**
2. Has there been any change in your general health in the past year? **Y N**
3. Have you had any serious illnesses or hospitalizations within the last few years? If so, describe: **Y N**

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5. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? **Y N**
   - B. Congenital Heart Disease? **Y N**
   - C. Cardiovascular Disease (Heart Attack, Angina, Coronary Artery Disease, Infective Endocarditis, High Blood Pressure, Palpitations, Heart Surgery, Stroke, Pacemaker?)..... **Y N**
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain? **Y N**
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness **Y N**
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? **Y N**
   - G. Liver Disease (Jaundice, Hepatitis?) **Y N**
   - H. Kidney Disease? **Y N**
   - I. Diabetes? **Y N**
   - J. Thyroid Disease? **Y N**
   - K. Arthritis? **Y N**
   - L. Stomach Ulcers or Colitis? **Y N**
   - M. Glaucoma? **Y N**
   - N. Osteoporosis? **Y N**
   - O. Radiation (X-ray) treatment for Cancer? **Y N**
   - P. Any disease, drug or transplant operation that has depressed your immune system? **Y N**
   - Q. Artificial joints placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee) **Y N**

   Location:_____

   Date Placed:_____

6. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? **Y N**
   - B. Anticoagulants (Blood Thinners)? **Y N**
   - C. Aspirin or drugs such as Aleve, Ibuprofen? **Y N**
   - D. High Blood pressure medications? **Y N**
   - E. Steroids (Cortisone, Prednisone, etc.)? **Y N**
   - F. Tranquilizers/Sedatives? **Y N**
   - G. Insulin or diabetic drugs? **Y N**
   - H. Digitalis, Inderal, Nitroglycerin, or other heart drug? **Y N**
   - I. Bisphosphonate (Aredia, Zometa, Actonel, Boniva, Fosamax, Didronel, Reclast)? **Y N**
   - J. Osteoporosis Medications? **Y N**

PLEASE LIST ANY AND ALL MEDICATIONS TAKEN:
(We can take a copy of your list of medications)

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7. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? **Y N**
   - B. Penicillin or other antibiotics? **Y N**
   - C. Sedatives, Barbiturates, Sulfites? **Y N**
   - D. Aspirin or Ibuprofen? **Y N**
   - E. Codeine or other pain killers? **Y N**
   - F. Latex or Rubber Products? **Y N**
   - G. Nitrous Oxide? **Y N**
   - H. Other allergies or reaction? Please, list **Y N**

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8. Do you smoke or chew Tobacco? **Y N**
   How much per day? _____
9. Have you had any serious problems associated with previous dental treatment? **Y N**
10. Any other disease, condition or problem not listed that you think the doctor should know about? **Y N**
11. **FOR WOMEN ONLY**
    - A. Are you pregnant? **Y N**
    - B. Are you nursing? **Y N**
    - C. Oral contraceptives? **Y N**

Notes:_____

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(I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.)

_____ Date

_____ Signature of Person Completing Health History

_____ Doctor's Initials