Dentistry By the Bay
Full Health History

Name: ______________________________________ Date: _________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

Are you under a physician's care now? _____ If yes who ____________________________________

Have you ever been hospitalized or had a major operation within the last 10 years? ________
If yes please explain ____

____

Have you ever had a serious head or neck injury? _______________
If yes please explain ____

____

Are you taking any medications, pills, or drugs? _________________
If yes please list ____

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _________
If yes when ____

Are you on a special diet? ________________ Do you use Tobacco? ____________________
Do you use controlled substances? _________ Do you need to pre-medicate? _____________
Do you take a blood thinner, Coumadin, Xarelto, or Heparin? _________________________________

Women: Are you…
Pregnant/trying to get pregnant? ____________ Nursing? _______________________________
Taking oral contraceptives? ________________

Are you allergic to any of the following?
Aspirin _____ Penicillin ____ Codeine _____
Metal _____ Latex _______ Sulfa ________
Local anesthetic ____ Acrylic ______
Other: ____

Name: ________________________________ Date: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	YES	NO	Radiation	YES	NO	Congenital Heart Disorder	YES	NO
Hepatitis A	YES	NO	Anaphylaxis	YES	NO	Heart Disease	YES	NO
Anemia	YES	NO	Herpes	YES	NO	Alzheimers Disease	YES	NO
Arthritis/Gout	YES	NO	Epilepsy	YES	NO	Drug Addiction	YES	NO
Excessive Bleeding	YES	NO	Seizures	YES	NO	Emphysema	YES	NO
Asthma	YES	NO	Shingles	YES	NO	High Cholesterol	YES	NO
Blood Disease	YES	NO	Fainting	YES	NO	Artificial Joint	YES	NO
Breathing Problems	YES	NO	Dizziness	YES	NO	Irregular Heartbeat	YES	NO
Bruise Easily	YES	NO	Kidney Problems	YES	NO	Blood Transfusion	YES	NO
Chemotherapy	YES	NO	Headaches	YES	NO	Liver Disease	YES	NO
Heart Attack/Failure	YES	NO	Low Blood Pressure	YES	NO	Cancer	YES	NO
Pain in Jaw Joints	YES	NO	Mitral Valve Prolapse	YES	NO	Tonsillitis	YES	NO
Ulcers	YES	NO	Osteoporosis	YES	NO	Tuberculosis	YES	NO
Heart Pacemaker	YES	NO	Psychiatric Care	YES	NO	Diabetes	YES	NO
Hepatitis B or C	YES	NO	High Blood Pressure	YES	NO	Artificial Heart Valve	YES	NO
Sickle Cell Disease	YES	NO	Sinus Trouble	YES	NO	Leukemia	YES	NO
Stroke	YES	NO	Thyroid Disease	YES	NO	Chest Pains	YES	NO
Cold Sores	YES	NO	Fever Blisters	YES	NO	Parathyroid Disease	YES	NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes.

Patient
Signature____Date______________