HEALTH HISTORY **Date: _____**

Name _____ Date of Birth _____

Date of last health care exam: _____What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving 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. **_____**

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.

Asthma	**No**	**Yes**	**Psychosis**	**No**	**Yes**
Diabetes	**No**	**Yes**	**Sore/Enlarged Lymph Nodes**	**No**	**Yes**
Anemia	**No**	**Yes**	**Previous Biopsies**	**No**	**Yes**
Epilepsy	**No**	**Yes**	**Slow-Healing Mouth Sores**	**No**	**Yes**
Hepatitis, Any Form	**No**	**Yes**	**Other Infections**	**No**	**Yes**
Rheumatic Fever	**No**	**Yes**	**Recurrent Illnesses**	**No**	**Yes**
Bacterial Endocarditis	**No**	**Yes**	**Joint Replacement**	**No**	**Yes**
HIV Positive or AIDS Related Complex	**No**	**Yes**	**Glaucoma**	**No**	**Yes**
Emphysema or other Respiratory Illnesses	**No**	**Yes**	**Abnormal Bleeding from a cut**	**No**	**Yes**
Abnormal Heart Condition	**No**	**Yes**	**Liver Disease (including Jaundice)**	**No**	**Yes**
Kidney Disease	**No**	**Yes**	**Unintentional Weight Loss/Gain**	**No**	**Yes**
Heart (Surgery, Disease, Attack)	**No**	**Yes**	**Latex Sensitivity**	**No**	**Yes**
Venereal Disease	**No**	**Yes**	**H.I.V. Infection/AIDS**	**No**	**Yes**

Do you have a prosthetic cardiac valve? No Yes
Do you have congenital heart disease (excluding MVP)? No Yes
If yes please be specific_____
Have you had a cardiac transplant? No Yes

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:

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 _____**

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

Name: _____

Please list any medications you are currently taking	**Dosage and frequency**	**Reason for taking medication**
1._____	**_____**	**_____**
2._____	**_____**	**_____**
3._____	**_____**	**_____**
4._____	**_____**	**_____**
5._____	**_____**	**_____**
6._____	**_____**	**_____**
7._____	**_____**	**_____**
8._____	**_____**	**_____**

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Prilosec? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines Such as St. John's Wort? No Yes
If yes, which ones?_____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ 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 change in my health and medication.

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

DOCTOR'S USE ONLY
Comments on patient interview concerning medical history:
_____
_____

Significant findings from questionnaire or oral interview:
_____
_____

Dental management considerations:
_____
_____

William S. Wooten, DDS _____ _____
Doctor ***Doctor Signature*** ***Date***