DENTAL IMPLANT SOLUTIONZ – HEALTH HISTORY

Patient Name: _____

Age: _____ Date: _____

Your answers are for our records only and will be confidential except where disclosure is required by law

Medical Questions:

1. Have there been any changes in your health in the past year	Y	N
2. Are you under the care of a physician	Y	N
3. Have you had any serious illnesses or operations	Y	N
4. Females: Are you pregnant	Y	N

Explain any "yes" _____

5. Please check if you have (or have had) any of the following problems

- ○ AIDS/HIV Positive
- ○ Anemia
- ○ Arthritis
- ○ Artificial Heart Valve
- ○ Artificial Joints
- ○ Asthma
- ○ Back Problems
- ○ Blood Disease
- ○ Cancer _____
- ○ Chemo/Radiation Therapy
- ○ Circulation Problems
- ○ Cortisone Treatments
- ○ Cough, Persistent/Bloody
- ○ Diabetes
- ○ Emphysema
- ○ Epilepsy

- ○ Fainting
- ○ Food Allergies
- ○ Headaches
- ○ Hearing Loss
- ○ Heart Murmur
- ○ Heart Problems
- ○ Hemophilia
- ○ Herpes
- ○ Hepatitis A B C D
- ○ High Blood Pressure
- ○ Jaundice
- ○ Jaw Pain
- ○ Kidney Disease
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Nervous Problems

- ○ Pacemaker
- ○ Psychiatric Care
- ○ Respiratory Disease
- ○ Rheumatic Fever
- ○ Seizure Disorder
- ○ Shingles
- ○ Shortness Of Breath
- ○ Sinus Problems
- ○ Stroke
- ○ Surgical Implants
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Ulcers/Acid Reflux
- ○ Vision Impairment
- ○ Other _____
- ○ None Of These

6. Allergies/Sensitivity

- ○ Anesthetic
- ○ Aspirin
- ○ Penicillin
- ○ Codeine
- ○ Sulfa
- ○ Iodine
- ○ Latex
- ○ Nickel
- ○ Other _____

7. List any medications (prescription & nonprescription)

_____
_____
_____

8. Pre- medication required before dental treatment?

YES NO Dosage taken _____

DENTAL IMPLANT SOLUTIONZ – HEALTH HISTORY

Dental Questions:

Please circle the appropriate answer for each condition/disease.

1. Have you had any serious problem(s) with any previous treatment? Y N
2. Have you ever had an injury to your face, jaw, or teeth? Y N
3. Do you ever feel like you have dry mouth? Y N
4. Have you ever had an unusual reaction to local anesthetic (numbing)? Y N
5. Do you wear full or partial dentures? Y N
6. Have you had any teeth replaced with a dental implant(s)? Y N
7. Have you had any teeth replaced with a fixed bridge(s)? Y N
8. Have you ever had any of the following treatment(s)?
    a. Gum/periodontal treatment Y N
    b. Orthodontics (braces) Y N
    c. Endodontics (root canal) Y N
    d. Extractions (teeth removed) Y N
    e. Bleaching/whitening Y N

9. **Are you taking any BISPHOSPHONATE medication (loss of bone density)** Y N

Check if you have any problems with the following:

- Bad Breath
- Bleeding, Sensitive Gums
- Canker Sore Or Cold Sores
- Clicking Or Popping Jaw
- Food Trapped Between Teeth
- Grinding Or Clenching Teeth

- Loose Teeth
- Broken Fillings
- Periodontal Treatment
- Sensitivity To Cold
- Sensitivity To Hot
- Staining

10. Do you smoke or use tobacco in any form? Y N
    a. How frequently? _____

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive at Dental Implant Solutionz and may be shared with other medical offices only as necessary. I will notify this dental office should any information change. I hereby authorize Dental Implant Solutionz to perform recommended services.

Signature of patient, or parent if a minor: _____ Date: _____

Doctors Signature: _____ Date: _____

LAST REVIEWED BY PATIENT AND DENTAL TEAM MEMBER: (IF MORE THAN 2 YEARS, COMPLETE NEW FORM)

Pt Initials: _____
Staff: _____
Date: _____

Pt Initials: _____
Staff: _____
Date: _____

Pt Initials: _____
Staff: _____
Date: _____