FLORIDA DENTAL IMPLANT CENTER
IMPLANT • COSMETIC • GENERAL

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HEALTH HISTORY

Name _____ Date _____

Date of last health care exam _____ What was this exam for? _____

Have you been hospitalized in the last 5 years (Please circle) YES NO

If yes, reason: _____

Please list the names and phone numbers of the physicians who are currently providing your care:

1. _____
2. _____
3. _____

For the following, please circle YES or NO if you HAVE or HAVE HAD any of these conditions. Your answers are for our records only and will be confidential.

Anemia or blood disorder, blood thinner	No	Yes	Hepatitis, any form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint replacement When placed?	No	Yes
Asthma	No	Yes	Kidney disease	No	Yes
Abnormal bleeding from a cut	No	Yes	Liver disease (including Jaundice)	No	Yes
Cancer or tumor	No	Yes	Sore/enlarged lymph nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other respiratory/lung illness	No	Yes	Previous biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy treatment	No	Yes
Fainting or dizzy spells	No	Yes	Rheumatic fever	No	Yes
Glaucoma	No	Yes	Slow healing mouth sores	No	Yes
Abnormal Heart or previous bacterial endocarditis	No	Yes	Unintentional weight loss/gain	No	Yes
Heart valve (artificial) or heart transplant	No	Yes	HIV infection/AIDS or ARC	No	Yes
Heart disease, heart attack, heart surgery	No	Yes	Venereal disease	No	Yes
Heart murmur, mitral valve prolapse	No	Yes	Other conditions	No	Yes
Heart stent When placed?	No	Yes	Recurrent illnesses	No	Yes

Are you currently taking any of these medications?

Pre-medication before dental treatment	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)	No	Yes
Antacids	No	Yes	Cardizem (diltiazem), Calan, Isoptin (Verapamil)	No	Yes
Dilantin or Tegretol	No	Yes	Biazin (clarithromycin)	No	Yes
Barbiturates (any)	No	Yes	Diflucan (fluconazole), Sporonox (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes			
Have you been treated with Bisphosphonate (Osteoporosis) drugs (Fosamax, Aredia, Zometra, Actonel, Boniva, Prolia)? If so, when did the treatment begin? When completed?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications, dietary or herbal supplements you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

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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?	No	Yes
Have you ever received a diagnosis of "high blood pressure"?	No	Yes
What is your normal blood pressure?		

Are you allergic or have you had a reaction to:		
Local anesthetics	No	Yes
Penicillin or other antibiotics	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes
Codeine, Valium or other sedatives	No	Yes
Latex or metals	No	Yes
Food Allergies	No	Yes
Other (please specify)		

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

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 office of any change in my health and medication.

Patient (Print Name) _____ Patient Signature _____ Date _____

Doctor (Print Name) _____ Doctor Signature _____ Date _____

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history: _____

Dental management considerations: _____