

# Health History

Terrence E. Robbins, DMD, Inc.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Dental Information

Please mark (X) Yes, No or DK (don't know)

|   | Yes                      | No                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|
| Are you currently experiencing dental pain?                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have clicking, popping or discomfort in the jaw?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have or have you ever had problems opening your mouth wide?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a serious injury to your face, jaw or neck?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any problems associated with previous dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear removable dentures or partials?                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Medical Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Please mark (X) Yes, No or DK (don't know)

|   | Yes                      | No                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list all: _____  |                          |                          |                          |
| _____   |                          |                          |                          |
| _____   |                          |                          |                          |
| _____   |                          |                          |                          |

|  | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|
| Are you taking any of the following drugs:   |                          |                          |                          |
| Antibiotics or sulfa drugs .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners (Coumadin, Warfarin, Plavix , Aspirin, Pradaxa, Xarelto or other) ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure medication .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone/Steroids .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tranquilizers /Barbiturates .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin or other diabetes medication .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerine .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Digitalis or other heart medications .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Are you taking any other prescription, over-the-counter or herbal medications? .....

If yes, please list all, including vitamins, natural or herbal preparations, diet supplements. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No DK  
Do you now or have you ever used marijuana .....

Yes No DK  
Do you now or have you ever used street or recreational drugs .....

If yes, please list all: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No DK  
Do you drink alcohol? .....

How much in a typical week? \_\_\_\_\_  
Do you smoke? .....

How much? \_\_\_\_\_  
Are you wearing any facial or oral piercings? ...

Do you wear contact lenses? .....

Yes No DK  
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelivia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? .....

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer. ....

Yes No DK  
**Joint Replacement:** Have you had an Orthopedic total joint replacement (hip, knee elbow, finger shoulder)? .....

Yes No DK  
**Women Only:** Are you pregnant? .....

If yes, number of weeks \_\_\_\_\_  
Are you Nursing? .....

Are you taking birth control pills? .....

Patient Name: \_\_\_\_\_

**Allergies**

Are you allergic to or have you had a reaction to:

|   | Yes                      | No                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|
| Local Anesthetic .....                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/antibiotics .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives or sleeping pills ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex (rubber) .....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eggs .....                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soy .....                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine .....                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Cardiac Diseases or Problems**

|  | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|
| Artificial (prosthetic) heart valve .....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous infective endocarditis .....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged valves or transplanted heart .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease (CHD)               |                          |                          |                          |
| Unrepaired, cyanotic CHD .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired (completely) in last 6 months ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired CHD with residual defects .....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina .....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves .....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack .....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur .....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other congenital heart defects .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse .....                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker .....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain upon exertion .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic heart disease .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thrombophlebitis or Blood Clot .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke .....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Diseases or Problems**

|                                    | Yes                      | No                       | DK                       |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| Abnormal Bleeding .....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion .....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date: _____                |                          |                          |                          |
| Hemophilia .....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV infection .....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Autoimmune disease .....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Systemic lupus erythematosus ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis .....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   | Yes                      | No                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|
| Emphysema .....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/ Leukemia .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Treatment .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes I or II .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating Disorder .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Malnutrition .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastrointestinal disease .....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acid Reflux/persistent heartburn .....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers .....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice or live disease ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy .....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting spells or seizures .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological disorder .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify _____                     |                          |                          |                          |
| Sleep Disorder .....                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental disorder .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify _____                     |                          |                          |                          |
| Recurrent infections .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of infection: _____                  |                          |                          |                          |
| Kidney Problems .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent swollen glands in neck .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe Headaches/migraines .....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe or rapid weight loss .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually transmitted disease .....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive urination .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any disease, condition, or problems not listed above that you think I should know about?  Yes  No  DK

Please explain: \_\_\_\_\_

*I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.*

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_