Health History Form

Burns Dental Care

Joint Replacement:	Yes	No	DK
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

If yes, when was the date? _____

Have you had any complications? _____

Women Only:	Yes	No	DK
Are you currently pregnant?	☐	☐	☐
If yes, number of weeks? _____			
Are you currently nursing?	☐	☐	☐
Do you currently take birth control pills or hormonal contraceptives?	☐	☐	☐

Please identify if you have any of the following:	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in the last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Please identify if you are currently take/use or plan to take/use:			
Antiresorptive (Fosamax, Actonel, Boniva, Reclast, Prolia, Used for osteoporosis or Paget's disease)	☐	☐	☐
Controlled substances (drugs)	☐	☐	☐
Tobacco/Nicotine	☐	☐	☐

If yes, please identify type: _____

Please identify if you have any allergies:

Please identify if you have any of the following conditions:			
Cardiovascular Disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Damaged Heart Valves	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Murmur	☐	☐	☐
Low Blood Pressure	☐	☐	☐
High Blood Pressure	☐	☐	☐
Other Congenital Heart Defects	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatic Heart Disease	☐	☐	☐
Abnormal Bleeding	☐	☐	☐
Anemia	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
Blood Transfusion	☐	☐	☐
Arthritis	☐	☐	☐
AIDS or HIV Infection	☐	☐	☐
Type of infection: _____			
Osteoporosis	☐	☐	☐
Persistent Swollen Glands in Neck	☐	☐	☐
Autoimmune Disease	☐	☐	☐
Recurrent Infections	☐	☐	☐

Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Neurological Disorders	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Bronchitis	☐	☐	☐
Sinus Trouble	☐	☐	☐
Chronic Pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating Disorder	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. Reflux/Persistent	☐	☐	☐
Ulcers	☐	☐	☐
Kidney Problems	☐	☐	☐
Glaucoma	☐	☐	☐
Thyroid Problems	☐	☐	☐
Stroke	☐	☐	☐
Hepatitis/Jaundice/Liver Disease	☐	☐	☐
Chest Pain upon Exertion	☐	☐	☐
Epilepsy	☐	☐	☐
Do You Snore?	☐	☐	☐
Sleep Disorder	☐	☐	☐
Mental Health Disorders	☐	☐	☐
If yes, please specify: _____			
Fainting Spells or Seizures	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: Phone: ( )

Do you have any disease, condition, or problem not listed above that you think I should know about?

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have red 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/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her 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 or Patient/Legal Guardian: **Date:**