DR. KINDER & DR. JACOB FAMILY DENTISTRY

HEALTH HISTORY

Today's Date: _____

Patient's Name: (First) _____ (Last) _____

Last Dental Check-up: _____ Last X-rays: _____ Birth Date: _____

Premedication: _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) or NO (N)
ALL RESPONSES ARE KEPT CONFIDENTIAL

Are you under a physician's care for a particular problem? Y N
If so, what? _____

Are you **TAKING** any prescription, non-prescription or herbal medications? Y N
If so, what? _____

Are you **ALLERGIC** to or have you had a bad reaction to:
Any medications? Y N
Please list: _____
Local Anesthetic? (Novocaine, etc.) Y N
Latex or rubber products? Y N
Types of food? Y N
Please list: _____

Do you have or have you ever had:

Scarlet Fever	Y	N	Epilepsy	Y	N
Rheumatic Fever	Y	N	Fainting	Y	N
Rheumatic Heart Disease	Y	N	Psychiatric Treatment	Y	N
Congenital Heart Disease	Y	N	Seizures	Y	N
Cardiovascular Disease	Y	N	Blood Disorder	Y	N
Angina	Y	N	Anemia	Y	N
Coronary Artery Disease	Y	N	Bleeding Disorder	Y	N
Damaged Heart Valve	Y	N	Bleeding Tendency	Y	N
Heart Attack	Y	N	Blood Transfusion	Y	N
Heart Murmur	Y	N	Bleed Easily	Y	N
Heart Surgery	Y	N	Kidney Disease	Y	N
High Blood Pressure	Y	N	Liver Disease (Yellow Jaundice, Hepatitis)	Y	N
Mitral Valve Prolapse	Y	N	Diabetes	Y	N
Pacemaker	Y	N	Thyroid Disease	Y	N
Palpitations	Y	N	Stomach Ulcers or Colitis	Y	N
Stroke	Y	N	Glaucoma	Y	N
Lung Disease	Y	N	Frequent Recurring Mouth Sores	Y	N
Asthma	Y	N	Implants Placed Anywhere in Your Body (Heart Valve, Hip, Knee, Etc.)	Y	N
Bronchitis	Y	N	Radiation (X-ray) Treatment for Cancer	Y	N
Chest Pain	Y	N	Chemotherapy	Y	N
Chronic Cough	Y	N	Clicking or Popping of Jaw Joint (TMJ), Pain Near Ear, Difficulty Opening Mouth, Grinding or Clenching of Teeth	Y	N
Emphysema	Y	N	Sinus or Nasal Problem	Y	N
Pneumonia	Y	N	Disease, Drugs, or Transplant Operations that have Depressed Your Immune System	Y	N
Severe Coughing	Y	N	HIV	Y	N
Shortness of Breath	Y	N	Recurrent Infection of any kind?	Y	N
Tuberculosis	Y	N			
Nervous Disorder	Y	N			
Breakdown	Y	N			
Convulsions	Y	N			
Dizziness	Y	N			

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Have you used marijuana or other street drugs in the last two months? Y N

Are you wearing contact lenses? Y N

Are you wearing removable dental appliances? Y N

Do you smoke or chew tobacco? Y N
Amount: _____ How Long: _____

Do you use alcohol? Y N
Amount: _____

Have you or any blood relative had problems with previous general anesthesia? Y N
(Going to sleep for surgery?)

Do you have any other diseases or condition not listed? Y N
Please list: _____

Do you wish to talk with the doctor privately about anything? Y N

FOR WOMEN ONLY PLEASE INITIAL AFTER READING

If you are using oral contraceptives, it is important that you understand that the antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance. **INITIALS:** _____

If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics, or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant! **INITIALS:** _____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE SAFEST CARE POSSIBLE.

Signature of Person Completing Health History: _____ Doctor's Initials: _____

FOR OFFICE USE ONLY.
If it has been longer than 6 months since your last appointment, please update below:

I have read my health history date: _____ and comfirm that it adequately states past and present conditions with the following changes:

Date Changes: _____ Patient's Signature: _____ Dr's Initials: _____

I have read my health history date: _____ and comfirm that it adequately states past and present conditions with the following changes:

Date Changes: _____ Patient's Signature: _____ Dr's Initials: _____