Lucy Torres RDHAP (707) 337-8895 smilesaver1@gmail.com

Today's Date: _____

HEALTH HISTORY

Patient's Name: _____ DOB: _____

Name of Responsible Party (or Power of Attorney/POA): _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. Are you on Hospice Care? ☐ No ☐ Yes Name/ Phone #: _____
2. Are you under a physician's care now? ☐ No ☐ Yes Name / Phone of Physician: _____
3. Have you had an artificial joint replacement, pins, screws? ☐ No ☐ Yes Please specify year: _____
4. Are you taking any medications, pills, or drugs? ☐ No ☐ Yes Please provide list of Medications: _____
   _____
5. Do you have depressed immune system? ☐ No ☐ Yes
6. Do you use tobacco? ☐ No ☐ Yes
7. Do you use controlled substances? ☐ No ☐ Yes
8. Are you **CURRENTLY** taking any of the following Bisphosphonates for Osteoporosis? ☐ No ☐ Yes (If YES mark below)
   ☐ Actonel ☐ Aredia ☐ Boniva ☐ Didronel ☐ Fosomax ☐ Prolia ☐ Reclast ☐ Skelide
9. Have you ever taken any medications of Bisphosphonates for Osteoporosis in the **PAST**? ☐ No ☐ Yes
   If YES, what did you take? _____ / When did you stop?: _____
10. Are you **CURRENLTY** on any Blood Thinners? ☐ No ☐ Yes (Mark Below)
    ☐ Aspirin ☐ Apixaban ☐ Dabigatran ☐ Edoxaban ☐ Rivaroxaban ☐ Warfarin ☐ Other: _____
11. Have you ever taken any Blood Thinners in the **PAST**? ☐ No ☐ Yes
    If YES, what did you take? _____ / When did you stop?: _____
12. Are you ALLERGIC to any of the following? ☐ No ☐ Yes (If YES mark below)
    ☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs

    Other Allergies not listed above: ☐ _____
13. Do you have, or have you had, any of the following? (Mark all that apply).

AIDS/ HIV Positive ☐Yes ☐No	Chest Pains ☐Yes ☐No	Hemophilia ☐Yes ☐No	Osteoporosis ☐Yes ☐No
Alzheimer's/ Dementia ☐Yes ☐No	Convulsions ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Radiation Treatments ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Anemia ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Herpes ☐Yes ☐No	Renal Dialysis ☐Yes ☐No
Angina ☐Yes ☐No	Emphysema ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Rheumatism/Arthritis ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	STD ☐Yes ☐No
Asthma ☐Yes ☐No	Glaucoma ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Stroke ☐Yes ☐No
Blood Disease ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Liver Disease ☐Yes ☐No	Thyroid Disease (Hyper) ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Thyroid Disease (Hypo) ☐Yes ☐No
Cancer, Tumors ☐Yes ☐No	Heart Pacemaker ☐Yes ☐No	Lung Disease ☐Yes ☐No	Tuberculoses ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Jaundice ☐Yes ☐No

List Other Conditions Not Listed Above: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ _____ / _____/ _____

Signature of Patient/ Responsible Party/ Power of Attorney Date