

Health Review

First name - Patient	Middle name	Last name - Patient	Patient birth date
_____	_____	_____	_____
Emergency contact	Emergency #		
_____	_____		
Height	Weight		
_____	_____		

Allergies

<input type="checkbox"/> Acetaminophen/Tylenol®	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Animals	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Augmentin	<input type="checkbox"/> Benadryl	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Flagyl	<input type="checkbox"/> Fluoride	<input type="checkbox"/> Food	<input type="checkbox"/> Hay fever/seasonal
<input type="checkbox"/> Ibuprofen/Motrin®/Advil®	<input type="checkbox"/> Latex	<input type="checkbox"/> Local anesthetic	<input type="checkbox"/> Metals
<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Mint	<input type="checkbox"/> Mold / Mildew	<input type="checkbox"/> Narcotics
<input type="checkbox"/> Nickel	<input type="checkbox"/> Novacane	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Opiates
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Pen VK	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Zythromax			
<input type="checkbox"/> Other			

Conditions

<input type="checkbox"/> Abnormal/excessive bleeding	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> ADD	<input type="checkbox"/> ADHD
<input type="checkbox"/> AIDS or HIV infection	<input type="checkbox"/> Alzheimer's/dementia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Angina
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis

Health Review

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|---|---|--|--|
| <input type="checkbox"/> Artificial Knee(s) | <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atrial Flutter |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Back problems | <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> Bladder Issues |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Brain Trauma |
| <input type="checkbox"/> Breathing problems/
respiratory disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer/chemotherapy/
radiation treatment | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Clotting Issues | <input type="checkbox"/> Cognitive Issues | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Cortisone or Steroid
medications | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting spells or seizures |
| <input type="checkbox"/> Fear of Needles | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Gastroesophageal Reflux
Disease (GERD) |
| <input type="checkbox"/> Gastrointestinal disease | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> G.E. Reflux/persistent
heartburn | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hard to Freeze | <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Heart rhythm disorder |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hepatitis, jaundice or liver
disease | <input type="checkbox"/> Hep B |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hives | <input type="checkbox"/> Hx of Blood Clots |
| <input type="checkbox"/> Hx of DVT | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) |
| <input type="checkbox"/> ITP | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Lichenoid Mucositis | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Low pain tolerance | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Lupis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Nocturnal Seizures |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> **OSTEOPOROSIS
MEDICATION** | <input type="checkbox"/> Osteoporosis/Paget's disease | <input type="checkbox"/> Other congenital heart defects |

Health Review

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|---|--|---|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> PCOS | <input type="checkbox"/> Persistent swollen glands in neck |
| <input type="checkbox"/> Physical Challenges | <input type="checkbox"/> Pre-diabetic | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Pre Medication |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Radiation / Cancer | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rheumatic heart disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Sarcoidosis of the lungs | <input type="checkbox"/> Sensitive to pain meds | <input type="checkbox"/> Severe headaches/migraines | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Sexually transmitted infection (STI) | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> SVT | <input type="checkbox"/> Syncope | <input type="checkbox"/> Systemic lupus erythematosus | <input type="checkbox"/> Thychemia |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> TMJ | <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Ulcerative Colitis (UC) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> West Nile |
| <input type="checkbox"/> Wheelchair Access | | | |
| <input type="checkbox"/> Other | | | |

Has there been any change to your general health within the past year?

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Are you taking any prescription or over-the-counter medicines?

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Do you use tobacco (smoking, snuff, chew, bidis)?

Do you have sleep apnea?

Health Review

Are you pregnant?

Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

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

Sign Name _____

Print Name _____ Date: _____