HEALTH REVIEW

Name: **Date:**

Phone_____ Email:_____ Address_____

Emergency Contact Person and Phone Number_____

Physician's Name _____ Physician's Phone _____

Date of last physical _____ Last Blood Pressure _____

Have you ever had an allergic/negative reaction to medications or substances?_____

Please explain _____ Other Allergies _____

Current medications_____

_____

If your medications change regularly or do not fit in the space provided, please attach a current copy to this form.

☐ Y ☐ N Have you ever been advised by your physician to take an antibiotic (pre-med) prior to dental treatment?

If yes, antibiotic name _____ Dosage _____

Pharmacy of preference _____ Phone # _____

☐ Y ☐ N Have you taken/are you taking bisphosphonates with nitrogen? Started: _____ Stopped: _____

Type: ☐ Zometa ☐ Aredia ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Other _____ Dosage _____

☐ Y ☐ N Women, are you pregnant, nursing, or taking birth control pills?_____

☐ Y ☐ N I would like to speak to the Doctor privately about a medical/dental concern.

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

Heart Condition	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Fainting Spells	☐ Y ☐ N
Heart Surgery	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N
Pacemaker	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Abnormal Bleeding	☐ Y ☐ N	Glaucoma	☐ Y ☐ N
Bacterial Endocarditis	☐ Y ☐ N	Hepatitis: Type ____	☐ Y ☐ N	Diabetes	☐ Y ☐ N
Angina/Heart Attack	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	Asthma/Emphysema	☐ Y ☐ N
Congenital Heart Defect	☐ Y ☐ N	HIV/AIDS/ARC	☐ Y ☐ N	Epilepsy/Seizures	☐ Y ☐ N
Congestive Heart Disease	☐ Y ☐ N	Cold Sores	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N
Mitral Valve Prolapse	☐ Y ☐ N	Blood Disorder	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Heart Murmur	☐ Y ☐ N	Inflammatory Disease	☐ Y ☐ N	Stroke	☐ Y ☐ N
Joint Replacement	☐ Y ☐ N	Tobacco Use	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Cancer: Type _____	☐ Y ☐ N	Drug Use	☐ Y ☐ N	Bruise Easily	☐ Y ☐ N
Radiation Therapy	☐ Y ☐ N	Alcoholism	☐ Y ☐ N	Latex Allergy	☐ Y ☐ N
Dry Mouth	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N	Anxiety	☐ Y ☐ N

List any conditions, problems, or diseases not listed above or explain any conditions marked ☑ Y _____

_____

Clinician's Notes: _____

TO THE BEST OF MY KNOWLEDGE ALL THE PRECEEDING ANSWERS ARE TRUE AND CORRECT. I UNDERSTAND IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM YOUR OFFICE OF ANY CHANGES.

Signed: _____ Date: _____

Dentist Signature: _____ Date: _____