Health History

Patient Name:_____

Have you ever been instructed to take Antibiotics before Dental Treatment? □Yes □No
Have you ever taken medication for osteoporosis or cancer chemotherapy? □Yes □No

Physician's Name:_____Date of Last Visit:_____
Address:_____Phone:_____

Please mark " Yes" or "No" to the indicate if you have ever had the following:

CARDIOVASCULAR
Heart Valve Replacement □Yes □No
Congenital Heart Defect □Yes □No
Mitral Valve Prolapse □Yes □No
Heart Murmur □Yes □No
Arteriosclerosis □Yes □No
Atrial Fibrillation □Yes □No
High/Low Blood Pressure □Yes □No
Angina □Yes □No
Pacemaker/ Defibrillator □Yes □No
Stroke: Date:_____ □Yes □No
Heart Attack:_____ □Yes □No

INFECTIOUS DISEASE
HIV/ AIDS □Yes □No
Swollen Glands □Yes □No
Tuberculosis □Yes □No
Herpes □Yes □No
Weight Loss □Yes □No

CIRCULATORY
Abnormal Bleeding □Yes □No
Anemia □Yes □No
Leukemia/Lymphoma □Yes □No
Blood Disease □Yes □No

NEUROLOGICAL
Dizziness/Fainting □Yes □No
Epilepsy/Seizure □Yes □No
Headaches □Yes □No
Vision/Hearing Problems □Yes □No

RESPIRATORY
Asthma □Yes □No
Cough, Bloody, Persistent □Yes □No
Emphysema □Yes □No
Sinus Infections □Yes □No
Shortness of Breath □Yes □No
Psychiatric Care □Yes □No
Swelling of feet or ankles □Yes □No

ENDOCRINOLOGICAL
Diabetes Type:_____ □Yes □No
Thyroid □Yes □No

MUSCULOSKELETAL
Osteoporosis □Yes □No
Joint Replacement □Yes □No

GASTROINTESTINAL
Ulcer/ Hyperacidity □Yes □No
Digestive Disorder □Yes □No
Hiatal Hernia □Yes □No
Liver Disease □Yes □No
Hepatitis, Type:_____ □Yes □No

OTHER
Arthritis □Yes □No
Auto Immune Problems □Yes □No
Cancer, Type:_____ □Yes □No
Kidney Disease □Yes □No
Tobacco Use_____ □Yes □No

Please list any other medical concerns/conditions we should know about:_____
Please list all prior **SURGERIES**:_____

MEDICATIONS
_____
_____
_____
_____
_____
_____

ALLERGIES
Penicillin □Yes □No
Codeine □Yes □No
Latex □Yes □No
Iodine □Yes □No
Dental Anesthetic □Yes □No
Other:_____

DENTAL
Clenching/Grinding □Yes □No
Clicking/Popping of Jaw □Yes □No
Tooth Sensitivity □Yes □No
Bleeding Gums □Yes □No
Orthodontic/ Braces □Yes □No
Periodontal Treatment □Yes □No

WOMEN
Pregnant, Due_____ □Yes □No
Nursing □Yes □No
Birth Control Pills □Yes □No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold Dr. Camillo L. Fontana, DMD, or any other member of his staff, responsible for any errors of omissions that I may have made in completing this form.

_____ _____
Signature of Patient/Guardian Date

_____
Doctors Signature