

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 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