# Palmetto Prosthodontics, LLC Health History Form

Patient Name: Birth Date: Date Created:

## Respiratory Problems

| | | | |
|---|---|---|---|
| Asthma | ◯ Yes ◯ No | If yes | |
| Tuberculosis | ◯ Yes ◯ No | If yes | |
| Sleep Apnea | ◯ Yes ◯ No | If yes | |
| Bronchitis/Emphysema/COPD | ◯ Yes ◯ No | If yes | |
| Additional Information About Breathing Problems | | omment | |

## Hematololgical Problems

| | | | |
|---|---|---|---|
| Anemia | ◯ Yes ◯ No | If yes | |
| Sickle Cell Disease/Trait | ◯ Yes ◯ No | If yes | |
| HIV Disease/AIDS | ◯ Yes ◯ No | If yes | |
| Bleading Disorders (e.g. Hemophilia) | ◯ Yes ◯ No | If yes | |
| Leukemia/Lymphoma | ◯ Yes ◯ No | If yes | |
| Coumadin/Warfarin Treatment (Blood Thinners) | ◯ Yes ◯ No | If yes | |
| Additional Information About Blood Problems | | omment | |

## Cardiovascular Problems

| | | | |
|---|---|---|---|
| High Blood Pressure/Hypertension | ◯ Yes ◯ No | If yes | |
| Hyperlipidemia (high cholesterol) | ◯ Yes ◯ No | If yes | |
| Arrhythmia | ◯ Yes ◯ No | If yes | |
| Angina/Chest Pain | ◯ Yes ◯ No | If yes | |
| Heart Attack or Myocardial Infarction | ◯ Yes ◯ No | If yes | |
| Prosthetic (artificial) Heart Valve | ◯ Yes ◯ No | If yes | |
| Congestive Heart Failure | ◯ Yes ◯ No | If yes | |
| Heart Bypass or Stent Surgery | ◯ Yes ◯ No | If yes | |
| Pacemaker/Defibrillator | ◯ Yes ◯ No | If yes | |
| Infective Endocarditis (bacterial infection of the heart that you would have been hospitalized to | ◯ Yes ◯ No | If yes | |
| Additional Information About Heart Problems | | omment | |

## Gastrointestinal Problems

| | | | |
|---|---|---|---|
| Hepatitis/Jaundice | ◯ Yes ◯ No | If yes | |
| Liver Disease | ◯ Yes ◯ No | If yes | |
| GERD/Reflux/Ulcers | ◯ Yes ◯ No | If yes | |
| Additional Information About Gastrointestinal | | omment | |

## Neurologial Problems

| | | | |
|---|---|---|---|
| Stroke/TIA/Mini-stroke | ◯ Yes ◯ No | If yes | |
| Multiple Sclerosis | ◯ Yes ◯ No | If yes | |
| Epilepsy/Seizure Disorder | ◯ Yes ◯ No | If yes | |
| Neuropathy/Neuropathic Pain (any areas that are numb or painful as a result of nerve damage) | ◯ Yes ◯ No | If yes | |
| Additional Information About Nervous System | | omment | |

## Endocrine Problems

| | | | |
|---|---|---|---|
| Diabetes | ◯ Yes ◯ No | If yes | |
| Thyroid Disorder | ◯ Yes ◯ No | If yes | |
| Additional Information About Endocrine Problems | | omment | |

## Other Problems

| | | | |
|---|---|---|---|
| Renal/Kidney Disease or Dialysis | ◯ Yes ◯ No | If yes | |
| Organ Transplant | ◯ Yes ◯ No | If yes | |
| Cancer | ◯ Yes ◯ No | If yes | |
| Radiation/Chemotherapy Treatment | ◯ Yes ◯ No | If yes | |
| CT/Autoimmune Disease (e.g., lupus, arthritis) | ◯ Yes ◯ No | If yes | |
| Artificial Joint (joint replacement) | ◯ Yes ◯ No | If yes | |
| Use/Used a Bisphosphonate Medication for Osteoprosis or Cancer Treatment (Fosamax, | ◯ Yes ◯ No | If yes | |
| Psych History or Depression | ◯ Yes ◯ No | If yes | |
| Additional Information and/or Other Problems | | omment | |

## Oral/Dental Problems

| | | | |
|---|---|---|---|
| Dry Mouth/Sjogren's Syndrome | ◯ Yes ◯ No | If yes | |
| Mouth Ulcers/Sores | ◯ Yes ◯ No | If yes | |
| Mouth Pain | ◯ Yes ◯ No | If yes | |
| Past Reaction to Local Anesthetics | ◯ Yes ◯ No | If yes | |
| Gums Bleed | ◯ Yes ◯ No | If yes | |
| Sudden Teeth Shifting | ◯ Yes ◯ No | If yes | |
| Grind or Clinch Teeth | ◯ Yes ◯ No | If yes | |
| Additional Information About Oral/Dental Problems | | omment | |

## Social History

| | | | |
|---|---|---|---|
| Cigarettes/Cigars/Pipes/Chewing Tobacco (how much and how long) | ◯ Yes ◯ No | If yes | |
| Alcoholic Beverages (how many drinks per week) | ◯ Yes ◯ No | If yes | |
| Recreational Drugs (list) | ◯ Yes ◯ No | If yes | |
| Women Only - Are You Pregnant or Trying to | ◯ Yes ◯ No | If yes | |
| Women Only - Are You Taking Oral Contraceptives | ◯ Yes ◯ No | If yes | |

## Medications/Hospitalizations/Allergies

| | | | |
|---|---|---|---|
| List Medications | | omment | |
| List Hospitalizations | | omment | |

Are You Allergic to Any of the Following?

| | | | |
|---|---|---|---|
| ☐ Penicillin | ☐ Metals | ☐ Latex | ☐ Aspirin |
| ☐ Sulfa Drugs | ☐ Acrylic | ☐ Local Anesthetics | ☐ Codeine |

## Other Medical Issues

| | | | |
|---|---|---|---|
| Do you have any other major illness not discussed elsewhere on this Health History Form? | ◯ Yes ◯ No | If yes | |

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.

Signature of Patient, Parent or Guardian:

X

Date:_____