Lowell Dental Care
Health History Form

Name: Date of Birth: Date:

_____

	Yes	No	?
Are you currently under the care of a physician?	☐	☐	☐

Physician's name and phone number: _____

_____

Are you in good health?	☐	☐	☐
Any changes in your general health in the past year?	☐	☐	☐
Have you had a serious illness, operation, or been hospitalized in the past 5 years?.....	☐	☐	☐

If yes explain: _____

_____

Are you taking, or have you recently taken any prescription or over the counter medications?.....	☐	☐	☐

If yes what? _____

_____

_____

Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or Phen- Fen (fenfluramine-phentermine combination)?.....	☐	☐	☐
Are you taking either Alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?.....	☐	☐	☐
Since 2001, have you been treated with bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting in Paget's disease, multiple myeloma or metastatic cancer?.....	☐	☐	☐
Do you used controlled substances (Drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?.....	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....	☐	☐	☐
Do you have any other diseases, conditions, or problems not listed that you think we should know about?.....	☐	☐	☐

If yes explain: _____

_____

Allergies:

Are you allergic to or have you had a reaction to any of the following?

	Yes	No	?
Local anesthetics	☐	☐	☐

If yes what? _____

Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐

If yes what? _____

Latex (Rubber)	☐	☐	☐
Lodine (Etodolac)	☐	☐	☐
Hay Fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Gluten	☐	☐	☐
Other	☐	☐	☐

If yes what? _____

Women Only:

Are you pregnant, trying to get pregnant or nursing?	☐	☐	☐

If yes, number of weeks: _____

Please mark (x) to indicate if you have had any of the following:

	Yes	No	?
Artificial Heart Valve	☐	☐	☐
Artificial Joint	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Abnormal Bleeding	☐	☐	☐
Anemia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune Disease	☐	☐	☐
Asthma	☐	☐	☐
Abnormal Blood Pressure (Low or High)	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Bronchitis	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Coronary Artery Disease	☐	☐	☐
Congenital Heart Defects	☐	☐	☐
Cancer / Chemotherapy / Radiation Treatment	☐	☐	☐
Chronic Pain	☐	☐	☐
Damaged Heart Valves	☐	☐	☐
Diabetes Type 1 or 2	☐	☐	☐
Eating Disorder	☐	☐	☐

	Yes	No	?
Epilepsy	☐	☐	☐
Fainting Spells or seizures	☐	☐	☐
Frequent cough (lasting longer than two weeks)	☐	☐	☐
G.E Reflux / Persistent heartburn	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Hemophilia	☐	☐	☐
Herpes	☐	☐	☐
Heart Murmur	☐	☐	☐
Jaundice or Liver Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Mental Health Disorders	☐	☐	☐
Neurological Disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Pacemaker	☐	☐	☐
Recurrent Infections	☐	☐	☐
Shingles	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Tonsillitis	☐	☐	☐

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist, or any other member of his/ her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: **Date:**

_____ _____