Family Healthcare of Northwest Ohio, Inc. - Dental Dept.

Health History

Patient Name_____ DOB_____ Date_____

Please circle all that apply, and explain if necessary.

Do you have a physician? Yes No Physician's Name_____ City/State_____ Phone Number_____	Any medications? Y N Blood thinner? Y N List all **medications** below (prescribed, over the counter, natural herbal, recreational, diet supplements, etc).
Do you have any **allergies**? Y N If yes, please list:	
List all hospitalizations:	
List all surgeries:	
List all illnesses:	
Any orthopedic total joint replacements (hip, knee, elbow, shoulder)? Y N	Date:
Has a physician or dentist recommended that you take an antibiotic prior to your dental treatment? Y N	
Have you been taking any medications that affect bone density (osteoporosis)? Y N	
Do you have any infectious diseases? Y N	

Cardiovascular Disease		**Endocrine**		**Respiratory**	
Heart related problems	Y N	Diabetes Type I	Y N	Asthma	Y N
Type/When		Diabetes Type II	Y N	Last attack:	
High blood pressure	Y N	Hyperthyroidism	Y N	Pulmonary disease (COPD)	Y N
Valve Disease	Y N	Hypothyroidism	Y N	Emphysema	Y N
Do you have a pacemaker?	Y N	Other:		Tuberculosis	Y N
Previous Infective Endocarditis	Y N			Other:	
Artificial heart valve	Y N				
Other:					
Behavioral Health		**Digestive**		**Hematologic (Blood)**	
Mental Health Problems	Y N	Cirrhosis of the liver	Y N	Abnormal bleeding	Y N
Mood disorders	Y N	Gastric Ulcer	Y N	Anemia	Y N
Bipolar	Y N	Hepatitis	Y N	Sickle Cell Anemia	Y N
Anxiety/Panic Disorder	Y N	Type		Aids or HIV	Y N
Other:		Other:		Other:	
Musculoskeletal		**Neoplasm (Cancer)**		**Neurologic**	
Arthritis	Y N	Cancer present/past	Y N	Stroke	Y N
Back problems	Y N	Where		Fibromyalgia	Y N
Neck Pain	Y N	Radiation	Y N	Multiple Sclerosis	Y N
Join Pain/TMJ	Y N	Chemotherapy	Y N	Epilepsy/Seizures	Y N
Osteoporosis	Y N	Remission	Y N	Fainting	Y N
Other		**Women Only**		**Social History**	
Urology		Pregnant	Y N	Alcohol/Drug Abuse	Y N
Kidney Problems	Y N	Due Date:		Current Tobacco use	Y N
Type		Nursing	Y N	Smoke or chew	
Dialysis	Y N	Birth control	Y N	Packs per day:	
Other		Hormone Therapy	Y N	Other:	

Patient/Guardian Signature_____Date_____

Provider Signature_____Date_____