Implant & Cosmetic Dentistry

1329 Main Street • Rochester, IN 46975-2107 (574)223-3121

Health History

Patient Name: ______________________ ______________________ ____ ______________________

Last First MI Preferred Name

Please list ALL Medications you are currently taking, including herbal, vitamins, supplements, etc,)
NAME - DOSAGE - REASON

Have you ever had an allergic reaction to the following?

- ☐ Allergies - seasonal
- ☐ Allergic Reaction - food/seafood/iodine
- ☐ Allergic Reaction - Anesthetic/Anesthesia
- ☐ Allergic Reaction - Codeine
- ☐ Allergic Reaction - Keflex
- ☐ Allergic Reaction - Penicillin
- ☐ Allergic Reaction - Latex
- ☐ Allergic Reaction - Sulfa
- ☐ Allergy or Allergic Reaction not listed
- ☐ No known Allergies

Please list further allergy/allergic reaction information:

Have you ever had any of the following? Please check all that appy:

- ☐ AIDS/HIV Positive
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy Treatment
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizzy Spells
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Immune System Disorder
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Nervous/Anxiety Disorders
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ/Clicking or Popping Jaw
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ No known health concerns

Please list further information for any health concern:

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ORAL HEALTH

Do You:

- ☐ Snore
- ☐ Smoke If so, packs per day______ # of years _____
- ☐ Drink soda How much/day ______
- ☐ Brush your teeth # of times per day______
- ☐ Frequency of flossing ____________
- ☐ Use an electric toothbrush
- ☐ Use a waterpik
- ☐ Have a dry mouth
- ☐ Have teeth/tooth sensitivity

Are you currently pregnant or nursing? ◯ Yes ◯ No

Do you have a hearing problem? ◯ Yes ◯ No

Have you ever had a facial cosmetic procedure? ______________________________ ◯ Yes ◯ No

Have you ever had any complications following dental treatment? ◯ Yes ◯ No

If yes, please explain:

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Name and Phone Number of Physician

Have you been admitted to a hospital or needed emergency care during the past two years? ◯ Yes ◯ No

If yes, please explain:

Please list any surgeries and their dates:

☐ ***To the best of my knowledge, I have accurately answered the above medical & dental questions. I understand the importance of an accurate health history. I agree to inform this dental office of any changes in my health history.**

Response Date: ____________