University of Louisville School of Dentistry | Health History Form

Patient Name: _____ DOB: _____/_____/_____

What is the reason for your dental visit today?

Have you experienced or had contact with someone with any of the following symptoms: Fever >101.5ºF (38.6ºC), severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal (stomach) pain, lack of appetite?
☐Yes ☐No (Please circle symptoms)

Have you or someone you have had contact with recently traveled outside the United States? ☐Yes ☐No
If yes, where? _____

Are you a Veteran? ☐ Yes ☐ No

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, list condition(s) you are being treated for:

Have you had a serious illness, operation or been hospitalized overnight in the past 5 years? ☐ Yes ☐ No If yes, what was the illness or problem?

List all drugs, medications of any kind you are taking including any vitamins, natural or herbal preparations and/or diet supplements:

Have you had an orthopedic total (artificial) joint (hip, knee, elbow, finger) replacement? ☐Yes ☐No If yes, date of surgery _____/_____/_____ Have you had any complications? ☐Yes ☐No			
Have you ever taken (or are scheduled to start taking) anti-osteoporosis/bisphosphonate drugs such as Aredia, Zometa, Fosomax, Actonel, Boniva, Reclast, Didronel, Prolia, Xgeva or Skelid? ☐Yes ☐No If yes, date treatment began:_____/_____/_____			
Are you allergic to, or have had a reaction to:			
Local anesthetics (Novocain)?	☐Yes ☐No	Penicillin or other antibiotics?	☐Yes ☐No
Aspirin or ibuprofen (Motrin)?	☐Yes ☐No	Codeine or other narcotics?	☐Yes ☐No
Latex (rubber)?	☐Yes ☐No	Metals (nickel, silver, etc.)?	☐Yes ☐No
Any other drug or medicine (please list):			

Do you have any special needs/accommodations?

☐ Blind/ Visually impaired	☐ Require American Sign Language (ASL)
☐ Deaf/ hearing impaired	☐ Do you need help understanding English?
☐ Require wheelchair	Which language do you prefer?_____

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Please check your response to indicate if you have any of the following diseases or problems:

Heart attack	☐Yes ☐No	Kidney disease/kidney failure/ dialysis	☐Yes ☐No
Angina/chest pains or exertion	☐Yes ☐No	Asthma	☐Yes ☐No
Heart failure or enlarged heart	☐Yes ☐No	Emphysema or chronic bronchitis	☐Yes ☐No
Arrhythmia/irregular heartbeat	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Hypertension/high blood pressure	☐Yes ☐No	Been exposed to anyone with tuberculosis	☐Yes ☐No
Endocarditis	☐Yes ☐No	Persistent cough for longer than 3 weeks	☐Yes ☐No
Congenital heart defect	☐Yes ☐No	Cough that produces blood	☐Yes ☐No
Artificial (prosthetic) heart valve	☐Yes ☐No	Fever, chills, night sweats	☐Yes ☐No
Heart pacemaker/defibrillator	☐Yes ☐No	Autoimmune disease/Rheumatoid arthritis	☐Yes ☐No
Heart transplant	☐Yes ☐No	Cancer/Chemotherapy/Radiation treatment	☐Yes ☐No
Anemia	☐Yes ☐No	Organ, bone marrow, or stem cell transplant	☐Yes ☐No
Sickle cell anemia/disease	☐Yes ☐No	HIV-positive or AIDS	☐Yes ☐No
Hemophilia	☐Yes ☐No	Sexually transmitted disease	☐Yes ☐No
Leukemia or lymphoma	☐Yes ☐No	Tobacco smoking	☐Yes ☐No
Tendency to bleed longer than normal	☐Yes ☐No	Alcohol or drug addiction	☐Yes ☐No
Stroke or transient ischemic attack (TIA)	☐Yes ☐No	Recreational drug use	☐Yes ☐No
Epilepsy, seizures or convulsions	☐Yes ☐No	Dementia/Alzheimer's	☐Yes ☐No
Thyroid disease	☐Yes ☐No	Cerebral palsy	☐Yes ☐No
Diabetes	☐Yes ☐No	Autism/Intellectually challenged	☐Yes ☐No
Stomach or intestinal ulcers	☐Yes ☐No	**WOMEN ONLY:**	
Gastritis or esophageal reflux	☐Yes ☐No	Pregnant?	☐Yes ☐No
Gastrointestinal disease	☐Yes ☐No	Taking birth control pills?	☐Yes ☐No
Hepatitis or yellow jaundice	☐Yes ☐No	Nursing?	☐Yes ☐No
Liver disease or cirrhosis	☐Yes ☐No		

DO YOU HAVE ANY OTHER DISEASE, MEDICAL CONDITION, OR PROBLEM NOT LISTED ON THIS FORM? ☐Yes ☐No

If yes, then please list below: