

University of Louisville School of Dentistry | Health History Form

Patient Name: _____ DOB: ____/____/____

What is the reason for your dental visit today?

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

Deaf/ hearing impaired

Require wheelchair

Require American Sign Language (ASL)

Do you need help understanding English?

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

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

If yes, then please list below:
