Vista Family Dentistry Health History Form

Date_____

Patient Name (First, MI, Last): _____ D.O.B: _____ Age: _____

Name of person completing this form: _____ Relationship to patient_____

Although dental personnel primarily treat in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your dental care. Thank you for answering the following questions.

Medical History

1. Do you have any health problems? **Yes** **No**
   If yes, please describe: _____
2. Have there been any changes in your health in the past year? **Yes** **No**
3. Are you currently under medical care? **Yes** **No**
   If yes, for what? _____
4. Are you taking any medications, pills, or drugs? **Yes** **No** If yes, please list on attached form.
5. Has a doctor or dentist recommended that you take routine antibiotic premedication prior to your dental treatment? **Yes** **No**
6. Have you had an orthopedic total joint replacement? **Yes** **No** Date? _____ Any Complications? _____
7. Have you taken bisphosphonate/antiresorptive agents for osteoporosis, Paget's Disease, cancer treatments, or hypercalcemia (ex: Alendronate, Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)? **Yes** **No**

8. **WOMEN ONLY:**
   Are you pregnant? **Yes** **No** Are you taking birth control pills/hormonal replacement? **Yes** **No**
   If yes, please list number of weeks: _____ Are you nursing? **Yes** **No**

9. Do you have any of the following **Allergies?** ☐ No Known Allergies
   ☐ Aspirin ☐ Codeine ☐ Dental Anesthetics (Novocaine) ☐ Iodine ☐ Latex
   ☐ Metals ☐ Pain Medication ☐ Penicillin/Amoxicillin ☐ Other _____

10. Do you have or have you ever had any of the following?

Artificial (Prosthetic) heart valve	Yes	No	Previous infective endocarditis	Yes	No
Damaged valves in transplanted heart	Yes	No	Unrepaired, cyanotic congenital heart disease	Yes	No
Repaired congenital heart disease with residual defects	Yes	No	CHD repaired completely in last 6 months	Yes	No

Except for the conditions listed above, antibiotic premedication is no longer recommended for any other form of heart disease.

11. Do you currently have or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	NO
Cardiovascular disease	☐	☐	Sexually Transmitted Disease	☐	☐	GI Disease	☐	☐
Angina	☐	☐	HIV/AIDS	☐	☐	Reflux/Heartburn	☐	☐
Arteriosclerosis	☐	☐	Chronic Cold Sores	☐	☐	Osteoporosis	☐	☐
Congestive Heart Failure	☐	☐	Arthritis	☐	☐	Chronic Pain	☐	☐
Damaged Heart Valves	☐	☐	Autoimmune Disease	☐	☐	Muscular Disorder	☐	☐
Heart Attack	☐	☐	Rheumatoid Arthritis	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Lupus	☐	☐	Hepatitis A, B, or C	☐	☐
Chest Pain w/Exertion	☐	☐	Asthma	☐	☐	Epilepsy	☐	☐
High/Low Blood Pressure	☐	☐	Bronchitis	☐	☐	Fainting/Seizures	☐	☐
Congenital Heart Defects	☐	☐	Emphysema	☐	☐	Neurological Disorders	☐	☐
Stroke	☐	☐	Tuberculosis	☐	☐	Multiple Sclerosis	☐	☐
Pacemaker	☐	☐	Sinus Trouble	☐	☐	Mental Health/Psychiatric Disorders	☐	☐
Blood Transfusion	☐	☐	Cancer/Chemo/Radiation	☐	☐	Autism Spectrum	☐	☐
Rheumatic Fever	☐	☐	Sleep Apnea	☐	☐	ADHD/ADD	☐	☐
Rheumatic Heart Disease	☐	☐	Kidney Problems	☐	☐	Headaches/Migraines	☐	☐
Abnormal Bleeding	☐	☐	Diabetes Type I or II	☐	☐	Tobacco Use	☐	☐
Blood Disorders	☐	☐	Thyroid Problems	☐	☐	Alcohol Abuse	☐	☐
Hemophilia	☐	☐	Eating Disorder	☐	☐	Drug Use/Abuse	☐	☐

Patient/Guardian Signature: _____ Dentist Signature: _____

Vista Family Dentistry Current Medication List

Patient Name: _____ Date: _____

Are you currently taking any prescription medications, over the counter medications, herbal or dietary supplements?

Yes _____ No _____

Medications	Reason Taking	How much	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Patient Signature: _____

Dentist Signature: _____