Health History Information

Name: ____________________ Date:____________ Kaiser #______________

Dental Health Information:

What are your primary concerns today?____________________

When was the last time you visited the dentist and for what reason?____________________

Are you concerned about the condition and appearance of your teeth?____________________

General Health Information:

How would you rate your overall health condition at present? **best** 10 9 8 7 6 5 4 3 2 1 **worst**

In the last 5 years, have you had a serious illness, operation or hospitalization? If so please describe ____________________

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Please circle YES or NO for the following questions. Leave blank if you are not sure

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Yes	No	Chest pain (Angina)	Yes	No	Alcohol/drug abuse	Yes	No	Diabetes I II
Yes	No	Heart Attack or stroke	Yes	No	Thyroid problems	Yes	No	Asthma
Yes	No	Bacterial Endocarditits	Yes	No	Hepatitis or liver problems	Yes	No	Radiation
Yes	No	Organ Transplant	Yes	No	Respiratory problems	Yes	No	Chemotherapy
Yes	No	Artificial Heart Valves	Yes	No	Psychiatric problems	Yes	No	Cancer
Yes	No	Congenital heart disease				Yes	No	Glaucoma
Yes	No	High/low blood pressure	Yes	No	Kidney/bladder disease	Yes	No	Artificial Joints
Yes	No	Irregular heart beat	Yes	No	Seizures			
Yes	No	Bleeding problems	Yes	No	AIDS/HIV	Yes	No	Osteoporosis

Have you taken any of the following Bisphosphonates: Fosamax Aredia Bonivia Evista Zometa Actonel Skelid Didronel Bonefos/Ostac

Do you have any allergies: Latex Penicillin Jewelry/Metal Aspirin Food Other:____________

Do you use tobacco in any form? Yes No__________ How much: specify____________

FOR WOMEN: Are you or could you be pregnant? No Yes How many months? ____________

Are you taking birth control pills? No Yes *** antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Consult your physician for further guidance***.

Please list all medications you are taking including any vitamins, herbs, recreational drugs or over-the-counter medications:

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To the best of my knowledge, I have answered every question completely and accurately. I will inform this office of any changes in my health and/or medications:

Patient and or guardian signature: ____________________Date____________

Reviewed by: DDS signature: ____________________**Date**____________