

PATIENT HEALTH HISTORY

During your visit you may be asked some questions to clarify your responses. We may also ask additional questions concerning your health that do not currently appear on this form. Your answers are for our records only and will be kept confidential.

Patient Name _____ Date of Birth: _____

Please list all the names and phone numbers of your primary care doctor and any other specialists who are **currently** providing you care or who you have seen in the past two (2) years:

- | | | | |
|----------------|-------------------|----------|-----------------|
| Doctor's Name: | Doctor's Address: | Phone #: | Type of Doctor: |
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

If you are currently receiving medical care, please explain the nature of that care: _____

Date of **last health care exam**: _____ What was this exam for? _____

Have you been **hospitalized** in the last 5 years? (Please circle): **NO YES** If öyesö, why? _____

DO YOU, OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:

PLEASE REVIEW EACH AND CIRCLE "YES" OR "NO"...DO NOT DRAW A LINE THROUGH ANY RESPONSE.

CARDIOVASCULAR			NERVOUS SYSTEM		
Abnormal Heart or Previous Bacterial Endocarditis?	No	Yes	Epilepsy?	No	Yes
Chest Pain?	No	Yes	Fainting or Dizzy Spells?	No	Yes
Congenital Heart Disease?	No	Yes	<input type="radio"/> Morning headaches?	No	Yes
Heart Attack? If yes, when? _____	No	Yes	Neurological Disorders?	No	Yes
<input type="radio"/> Heart Disease?	No	Yes	OCULAR (EYES)		
Heart Murmur?	No	Yes	Contact Lenses?	No	Yes
Heart Pacemaker?	No	Yes	Glaucoma?	No	Yes
Heart Stent? When was it placed?	No	Yes	PSYCHOLOGICAL		
Heart Surgery (other)?	No	Yes	Anorexia/Bulimia	No	Yes
Heart Valve (artificial) or Heart Transplant?	No	Yes	<input type="radio"/> Depression?	No	Yes
CIRCULATORY			<input type="radio"/> Excess daytime sleepiness?	No	Yes
Anemia or Blood Disorder?	No	Yes	<input type="radio"/> Inability to focus?	No	Yes
Abnormal Bruising or Bleeding?	No	Yes	<input type="radio"/> Nervous/Anxious?	No	Yes
<input type="radio"/> High or low blood pressure?	No	Yes	<input type="radio"/> Never feel rested?	No	Yes
DIGESTIVE			Psychiatric/psychological care?	No	Yes
<input type="radio"/> Acid Reflux? Frequent heartburn? (GERD)	No	Yes	REPRODUCTIVE		
<input type="radio"/> Frequent bathroom trips during the night?	No	Yes	Human Papilloma Virus (HPV)?	No	Yes
Hypoglycemic?	No	Yes	Venereal Disease?	No	Yes
Stomach sensitivity?	No	Yes	RESPIRATORY		
Ulcers?	No	Yes	Allergies?	No	Yes
<input type="radio"/> Unintentional, Significant Weight Loss/Gain?	No	Yes	<input type="radio"/> Asthma	No	Yes
ENDOCRINE SYSTEM			Emphysema or other Lung Illnesses?	No	Yes
<input type="radio"/> Diabetes?	No	Yes	Hay Fever?	No	Yes
<input type="radio"/> Thyroid Problems? (Hypo) or (Hyper)	No	Yes	<input type="radio"/> Sinus Infections or other trouble?	No	Yes
IMMUNE SYSTEM			<input type="radio"/> Have you been told you stop breathing?	No	Yes
Hepatitis? If öyesö, which type:	No	Yes	<input type="radio"/> Have your tonsils been removed?	No	Yes
H.I.V. Infection/AIDS or ARC?	No	Yes	<input type="radio"/> Recurring tonsillitis?	No	Yes
Lymph Nodes ö Sore or Enlarged?	No	Yes	<input type="radio"/> Waking up coughing or gasping?	No	Yes
Recurrent Illnesses?	No	Yes	SORES/TUMORS		
Rheumatic Fever?	No	Yes	Cold Sores/Fever Blisters?	No	Yes
MUSCULOSKELETAL			Radiation or Chemotherapy?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Slow-Healing Mouth Sores?	No	Yes
Joint Replacement? If öyesö, when? _____	No	Yes	Tumors?	No	Yes
Type of joint? _____			OTHER CONDITIONS NOT MENTIONED?		

ARE YOU CURRENTLY TAKING ANY OF THESE MEDICATIONS?
(PLEASE CHECK ✓ ALL THAT APPLY)

- Antibiotic premedication before dental treatment?
Antacids? Type:
Barbiturates? (any)
Biaxin (clarithromycin)
Calan
Cardizem (diltiazem)
Cortisone?
Diflucan (fluconazole)
Dilantin
Isoptin (Verapamil)
Kava-Kava?
Prilosec (omeprazole)?
St. John's Wort
Serzone (nefazodone)
Sleeping pills
Sporonox (itraconazole)
Tagamet (cimetidine)
Tegretol
Tranquilizers

Have you been treated with any of the following Bisphosphonate drugs: (Circle One)
(Actonel, Aredia, Boniva, Fosamax, Zometa)? No Yes
If so, when did the treatment begin? When did the treatment end?

Have you ever taken any prescription drugs such as Fen-phen for weight loss? No Yes
Do you consume grapefruit juice, grapefruits or grapefruit seed extract? No Yes

Please list all medications you are currently taking, with the dosage(s) and for what purpose it is being taken:
1. 2.
3. 4.

Please list any dietary or herbal supplements you are taking, and for what purpose:
5. 6.
7. 8.
9. 10.

Women: Are you pregnant? No Yes # of months
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of high blood pressure?
What is your normal blood pressure? S /D Today: /

Are you allergic or have you had a reaction to:

- a. Local anesthetics No Yes
b. Penicillin or other antibiotics No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or other sedatives No Yes
e. Latex or Metals No Yes
f. Other medications or substances (please specify)

Tobacco, Alcohol, Drugs:

Do you use tobacco? No Yes
If yes, circle type: Smoke Chew
For how long? How much per day?
Do you want to quit using tobacco? No Yes
Do you consume alcohol? No Yes
If yes, approximately how many alcoholic beverages per week?
Do you use any mood altering drugs other than those previously listed? No Yes

The following measurements are needed to: (1) help in determining the type and amount of medications to be administered during dental treatment, if any, and (2) help identify early indicators of potential sleep disordered breathing.

HEIGHT: _____ WEIGHT: _____ NECK CIRCUMFERENCE: _____ WAIST: _____

Do you have any additional information or comments that you feel are important for Dr. Doner to take into consideration when evaluating and planning your care?

PATIENT (or PARENT/GUARDIAN) ACKNOWLEDGEMENT & AUTHORIZATION

I understand the above information is necessary to provide me/my child/or my charge with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to contact the respective health care provider or agency, who may release such information to you. I will notify your office of any future changes in my health and medications.

Patient (Print Name)

Patient/Parent or Guardian Signature

Date

NOTE TO PATIENT: DO NOT WRITE BELOW THIS AREA

******* THIS SECTION IS FOR DOCTOR or OTHER CLINICIAN USE ONLY *******

Clinician Instructions: Carefully review and evaluate all patient responses. Make sure patient, parent or guardian has answered all questions and signed where appropriate.

For any SDB-related responses for which the patient indicated a positive "Yes" answer, fill in the circle adjacent to that question using black ink. Complete the rest of this segment, sign and date the form and provide the completed form to Dr. Doner for his review.

Significant findings from questionnaire or oral interview:

Dental management considerations:

Blood pressure: _____ **Pulse:** _____ **O₂ Sat:** _____

BMI: _____ **SDB RISK INDICATORS: NO LOW MOD HIGH**
(CIRCLE ONE)

***** To be signed by Dental Assistant or Dental Hygienist and Doctor Doner *****

Dental Assistant or Hygienist (Print & Sign) Date

Dr. Scott C. Doner - Signature Date