

# Portland Periodontics

## PATIENT HEALTH HISTORY

**Patient's Name** \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Answer all questions by circling Yes (Y) or No (N)**

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem?.....Y N  
If so, please explain \_\_\_\_\_  
\_\_\_\_\_
5. **PHYSICIAN'S NAME** \_\_\_\_\_  
**PHYSICIAN'S PHONE NUMBER** \_\_\_\_\_
6. Have you **ever** had any serious illnesses or surgeries? .....Y N  
If so, describe: .....Y N  
\_\_\_\_\_  
\_\_\_\_\_

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
  - A. Infective endocarditis? .....Y N
  - B. Congenital Heart Disease? .....Y N
  - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Mitral Valve Prolapse, Rheumatic fever, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .....Y N
  - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain)?.....Y N
  - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .....Y N
  - F. Bleeding Disorder, Anemia, Bleeding Tendency, or Blood Transfusions? .....Y N
  - G. Do you bruise easily? .....Y N
  - H. Liver Disease (Jaundice, Hepatitis A, B or C)? .....Y N
  - I. Kidney Disease / Renal Dialysis? .....Y N
  - J. Diabetes? .....Y N
  - K. Thyroid Disease (Goiter)? .....Y N
  - L. Arthritis? .....Y N
  - M. Stomach Ulcers or Colitis? .....Y N
  - N. Glaucoma? .....Y N
  - O. Implants or artificial joints placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..Y N
  - P. Radiation (X-ray) or Chemo Therapy treatment for Cancer?.....Y N
  - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
  - R. Sinus or Nasal problems? .....Y N
  - S. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
  - T. AIDS/HIV Positive.....Y N

**ARE YOU USING ANY OF THE FOLLOWING:**

- A. Antibiotics? .....Y N
- B. Anticoagulants (Blood Thinners)?.....Y N
- C. Aspirin or drugs such as Aleve, Ibuprofen? .....Y N
- D. High Blood Pressure medications? .....Y N
- E. Steroids (Cortisone, Prednisone, etc.)?.....Y N
- F. Tranquilizers? .....Y N
- G. Insulin or Oral Anti-Diabetic drugs? .....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug?.....Y N
- I. Bisphosphonate (Aredia, Zometa, Actonel, Boniva, Fosamax, Skelid, Didronel).....Y N
- J. Bisphosphonate Reclast Injection once a year.....Y N
- K. Please list any and all medications you have taken within the PAST YEAR, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocain, etc.)? .....Y N
- B. Penicillin or other antibiotics? .....Y N
- C. Sedatives, Barbiturates, Sulfites?.....Y N
- D. Aspirin or Ibuprofen? .....Y N
- E. Codeine or other pain killers?.....Y N
- F. Latex or Rubber Products?.....Y N
- G. Other allergies or reactions? Please, list .....Y N  
\_\_\_\_\_
10. Do you smoke or chew tobacco?.....Y N  
How much per day? \_\_\_\_\_ How many Years? \_\_\_\_\_
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Do you use recreational drugs? List.....Y N
13. Have you had any serious problems associated with any previous dental treatment?.....Y N  
\_\_\_\_\_
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N

**16. FOR WOMEN ONLY**

- A. Are you Pregnant, or **is there any chance** you might be Pregnant?.....Y N
- B. Are you nursing?.....Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**I verify that the above is true and correct. I understand that the information I provide on this form is essential to protect me and to ensure that proper care is provided. I will report any future changes in my health to Dr, Goldwyn as soon as possible. I have read and understood each question, and I will discuss this history with Dr. Goldwyn prior to initiation of any treatment.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Completing Health History

\_\_\_\_\_  
Clinician's Initials

**Medical Update:** I have read my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

\_\_\_\_\_  
Date Exceptions or changes Patient's Signature Clinician's Initials

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