Confidential Health History

Rogers Family Dentistry
8284 Beechmont Avenue
Cincinnati, OH 45255
Phone: 513-231-1012

Patient's Name: _____ Date of Birth: _____
Last First Middle

Patient's Sex: M F Prefer to be called: _____

Family Physician: _____ MD Phone: _____ Last Physical: _____

Are you currently being treated by a physician? Y N If yes, for what condition(s)? _____

List all allergies (medications, foods, materials): _____

_____.

Women: Are you pregnant? Y N Due Date: _____ Are you nursing? Y N

Have you ever been treated for any of the following medical conditions? Check all that apply.

__ Hepatitis	__ **Mitral Valve Prolapse**	__ Pacemaker
__ Diabetes	__ **Heart Murmur**	__ Heart Surgery
__ Tuberculosis	__ Heart Attack: Date: _____	__ **Heart Defect**
__ Thyroid Disease	__ Blood Pressure: High Low	__ Rheumatic Fever
__ Kidney Disease	__ Hemophilia/Blood Disorder	__ Bruise Easily
__ Epilepsy/Seizures	__ Chronic Sore Throat	__ Allergies
__ Arthritis	__ Auto Immune Disorder	__ Sinus Problems
__ Steroid Drug Treatment	__ Dizziness/Inner Ear Problems	__ HIV or AIDS
__ Mental Illness	__ Drug or Alcohol Abuse	__ Venereal Disease
__ Asthma/Respiratory	__ Night Sweats	__ Radiation Treatment
__ Severe/Frequent Headaches	__ Cancer: Type: _____	__ **Joint Replacement**

Please Complete Back Side

Check any of the following to which you have had an allergic or adverse reaction:

__ Aspirin __ Penicillin __ Erythromycin __ Latex
__ Pain Medication __ Codeine __ Dental Anesthetics __ Iodine
__ General Anesthetics __ Metals __ Sulfa
__ Other medications? Please list: _____

Please list all medications you take, *prescribed or over-the-counter*: _____

_____.

Attach a list of medications if you need more room.

****It is *very important* for you to notify us if you currently take or ever start to take any of the following medications:**

Aspirin Daily **Plavix** **Coumadin (Warfarin)**
Heparin **Any other blood thinner/anti-coagulant**
Fosamax (alendronate) **Actomel** **Zomeda** **Aredia**
Didrocal **Any other bisphosphonate drug**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any change in my medical status.

Signature: _____ Date: _____

Dental History

Check any that apply:

__ Bleeding Gums
__ Gum/Periodontal Disease
__ Fear of dental procedures
__ Reaction to local anesthetics
__ Growth or sore lasting longer than 2 weeks
__ Breath Odor
__ Fever blisters or mouth sores
__ Tobacco Use
  __ Cigarettes __ Pipe
  __ Chewing/Dip __ Cigar
__ Clenching or grinding teeth
__ Pain in or near ears
__ Frequent Headaches
__ Cracking, popping, or pain in the jaw
__ Removable partial denture
  Upper: ___ Approx. Age: _____
  Lower: ___ Approx. Age: _____
__ Full Denture
  Upper: ___ Approx. Age: _____
  Lower: ___ Approx. Age: _____

Has periodontal (gum) treatment ever been recommended to you? Y N Completed? Y N

Do you like your smile? Y N If no, why? _____
Do you breathe through your mouth when awake? Y N When asleep? Y N
How many times a day do you brush? _____ How many times per *week* do you floss? _____
Do you have any other dental concerns? _____

Office Use Only

Date: _____ Comments: _____ Initials: _____

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Date: _____ Comments: _____ Initials: _____