Maple Leaf Implant & General Dentistry ***Patient Health History***

Patient Full Name: Print: _____

Last First Middle

What is your estimate of your general health? Circle one: Excellent Good Fair Poor

Have you ever been hospitalized or had surgery? Circle: Yes No

If yes, please give reason:_____
_____
_____

Are you currently under a physicians care? Circle: Yes No

If yes, please state nature of care: _____
_____
_____

Please list names of physicians who provide your health care:

_____
_____
_____

Do you take an antibiotic premedication for your dental visits? If yes, please explain why: _____

_____

Do you have a Heart Stent? Circle: Yes No If so, when was it placed? _____

Have you had a joint replacement? Circle: Yes No If so, when? _____

Do you take a blood thinner? Circle: Yes No If yes, what do you take? _____

Please check if applies: tobacco ____ (Smoke, chew, dip) Vape ____ Consume Alcohol _____ Mood altering drugs other than those previously listed above ____
If yes to alcohol, how may alcoholic beverages per week? ____

How many meals do you eat per day? ____ **Any dietary restrictions?** If yes, please specify.
_____

Amount of sugar in your diet? Circle: none slight moderate high

(Flip over to next page)

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Please list all medications you are currently taking (prescription and non-prescription, including regular doses of aspirin:

_____
_____
_____
_____
_____

Please list any allergies and your reaction.

_____
_____
_____

Do you have any allergic reactions? Check all that apply: Local anesthetics or epinephrine____

Aspirin____ Ibuprofen____ Tylenol____ Latex____ Metals____ Penicillin or other antibiotics____

Codeine____ Valium____ Hydrocodone____ Oxycodone or other sedatives_____

Please specify others not listed:_____

Women Only, please check if applies: Are you pregnant? _____ Are you a nursing mother? ____
If no, are you planning a pregnancy in the near future? ____ Are you taking birth control pills? ____

Men Only: Are you currently or have you ever taken ED medicine (Viagra, Cialis, Levitra)? Yes____ No____

Have you been treated with Bisphosphonate drugs? (Fosamax, Aredia, Zometa, Actonel, Boniva, RECLAST, or Prolia)

Yes____ No____

If yes, when did treatment begin? _____ **When did treatment end?** _____

EMERGENCY CONTACT: (Please provide name and telephone number) _____

_____

Preferred Pharmacy:_____

(Be sure to complete next page, sign and date)

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Indicate which of the following conditions you have or have had. By checking it will indicate a "YES" response, leaving blank will indicate "NO" response.

__Anemia
__Arthritis
__Asthma
__Blood Thinners
__Cancer
__Chronic Bronchitis
__Congenital Heart Defect
__Cystic Fibrosis
__Diabetes 1
__Diabetes 2
__Diverticulosis
__Dizziness
__Emphysema/COPD
__Epilepsy
__Gerd
__Glaucoma
__Tuberculosis
__Other

__Head Injury
__Heart Disease
__Hepatitis
__High Blood Pressure
__High Cholesterol
__HIV
__Joint Replacement
__Kidney Disease
__Liver Disease
__Low Blood Pressure
__Medications
__Mental Disorders
__Multiple Sclerosis
__Nervous Disorders
__Pacemaker
__Pericarditis
__Tumors

__Pneumonia
__Pregnancy
__PREMED
__Radiation Treatment
__Recent Heart Attack
__Respiratory Problems
__Rheumatic Fever
__Rheumatism
__Seasonal Allergies
__Seizures
__Sinus Problems
__Stomach Problems
__Stroke
__Syncope/Fainting
__Thyroid
__Tobacco (any type)
__Ulcers

If any conditions or alerts selected above need further clarification or you checked Other, please describe below:

_____

_____

If you checked cancer, please specify what type of cancer:_____

By signing this Health History, I acknowledge that I have reviewed and answered ALL questions/alerts to the best of my knowledge. There are no other medical conditions, medications or allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature:_____ **Date** _____