



HEALTH HISTORY

SARMENT, DDS, MS, PC
Implantology & Periodontics

Patient's name

Date

- 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 under a physician's care for a particular problem? Y N
- 5. Have you ever had any serious illness, operations or hospitalization? Y N
If yes, please explain _____

Are you using any of the following?

- 6. Antibiotics Y N
- 7. Anticoagulants Y N
- 8. Aspirin or drugs such as Motrin, Ibuprofen, Aleve Y N
- 9. High blood pressure drugs Y N
- 10. Steroids (i.e. Cortisone) Y N
- 11. Tranquilizers Y N
- 12. Insulin or other anti-diabetic Y N
- 13. Heart medication Y N
- 14. Herbal or holistic remedies Y N

15. Vitamins Y N

16. Do you smoke or chew tobacco Y N

17. History of alcohol or chemical dependency Y N

18. Any serious problem with any previous dental treatment Y N

19. Any other disease, condition or problem not listed above _____

20. Do you wish to speak to the doctor privately about anything Y N

Do you need PREMEDICATION for your dental appointment? Y N

If yes, why? _____

Which antibiotic (if you know)? _____

Are you ALLERGIC or have you had adverse reactions to the following?

- 21. Local anesthesia (i.e. Novocaine) Y N
- 22. Penicillin / other antibiotics Y N
- 23. Sedative, barbiturates Y N
- 24. Aspirin, ibuprofen Y N
- 25. Codein or other pain killer Y N
- 26. Latex or rubber products Y N
- 27. Other allergic reactions Y N

Do you have or have you ever had:

28. Implants placed anywhere in your body
 Heart valve Pacemaker Hip
 Knee

29. Rheumatic heart disease Y N

30. Congenital heart disease Y N

31 Cardiovascular disease Y N

- Heart attack Heart murmur
- Coronary artery disease Angina
- High blood pressure Stroke
- Heart palpitations Heart surgery
- Pacemaker

32. Lung disease Y N

- Asthma Emphysema Chronic cough
- Bronchitis Pneumonia Tuberculosis

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33. Nervous disorders Y N
 Seizures Convulsiona Epilepsy

