John E. Truitt, D.D.S, P.C.

Health History

Patient's Name:____Date of Birth:____________ Today's Date:_____________

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES OR NO **ALL RESPONSES ARE KEPT CONFIDENTIAL**

So that we can safely treat you, it is very important that you are truthful when filling out your health questionnaire. You MUST list ALL medications & any medical problems.

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**
5. Have you EVER had any serious illnesses, operations or hospitalizations? If so, describe **Y N**

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6. Height___________Weight__________
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heath Disease? **Y N**
   - B. Congenital Heart Disease? …………………………**Y N** Cardiovascular Disease (Heart Attack, Heart Trouble, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?
   - C. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?......................**Y N**
   - D. Do you have sleep apnea or use a C-PAP machine? **Y N**
   - E. Seizures, Convulsions, Epilepsy, Fainting, or Dizziness? **Y N**
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? **Y N**
   - G. Liver Disease (Jaundice, Hepatitis)?..............**Y N**
   - H. Kidney Disease?.. **Y N**
   - I. Diabetes?.. **Y N**
   - J. Thyroid Disease? ………………………………………. **Y N**
   - K. Arthritis? …………………………………………………… **Y N**
   - L. Stomach Ulcers or Colitis?........................... **Y N**
   - M. Implants placed anywhere in your body**?** (Heart Valve, Pacemaker, Hip, Knee)?.........**Y N**
   - N. Glaucoma?...**Y N**
   - O. Radiation (X-Ray) treatment for Cancer?.......**Y N**
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? **Y N**
   - Q. Sinus or Nasal problems?........................**Y N**
   - R. Any Disease, drug or transplant operation that has depressed your immune system? **Y N**
8. **ARE YOU USING ANY OF THE FOLLOWING**:
   - A. Antibiotics ………………………………… **Y N**
   - B. Anticoagulants (Blood Thinners)?......**Y N**
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? **Y N**
   - D. High Blood Pressure medications? **Y N**
   - E. Steroids (Cortisone, etc.)? **Y N**
   - F. Tranquilizers? **Y N**
   - G. Inhalers (Albuterol, others)? **Y N**
   - H. Insulin or Oral Anti-Diabetic drugs? **Y N**
   - I. Digitalis, Inderal, Nitroglycerin or other heart drug? **Y N**
   - J. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for osteoporosis or chemotherapy for multiple myeloma, etc.)? **Y N**

K. **Please list any and all medications, including inhalers, prescription medication, over the counter medications, herbal or holistic remedies, vitamins or minerals:**

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9. **Are you allergic to or have you had an adverse reaction to:**
   A. Local Anesthesia (Novocain, etc.)? **Y N** D. Codeine or pain killers? **Y N**
   B. Penicillin or other antibiotics? **Y N** E. Aspirin or Ibuprofen? **Y N** Other allergies or reactions?
   C. Sedatives, Barbiturates? **Y N** F. Latex or Rubber Products? **Y N** ______________________

10. Do you smoke or chew Tobacco? **Y N** How much per day?_________
11. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care provide?

12. Have you had any serious problems associated with any previous dental treatment?

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13. Have you or an immediate family member had any problem associated with general anesthesia, IV sedation or local anesthesia?

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

15. Do you wish to talk to the doctor privately about anything?

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 physicians for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible and that I will have the opportunity to discuss my Health History with my Doctor during this appointment.

______________ ______________________ ______________________

Date **Signature of Person Completing Health History** **Doctor's Initials**