TYLER DENTAL ARTZ
4-7340 Home Street, Mission, BC V2V 3Y6
(604) 826-9014

HEALTH HISTORY

PATIENT NAME ______________________________ **DATE** ______________

Physician: ______________________________ **Phone:** ______________
Any other health care provider: ______________________ **Phone:** ______________

Date of last health care exam: ______________ What was this exam for? ______________

Have you been hospitalized in the last 5 years? (Please circle) No Yes
If yes, reason: ______________________________

Have you had any serious operation, illness or condition? (Please circle) No Yes
If yes, reason: ______________________________

Are you currently under physicians care? No Yes If yes, nature of care: ______________

Do you have any of the following or have had? circle yes or no.

Condition			Condition		
Anemia or Blood Disorder	No	Yes	Hepatitis (A/B/C)	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Asthma or Trouble Breathing	No	Yes	Kidney Disease	No	Yes
Persistent Cough	No	Yes	Sinus infections	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Sinus headaches	No	Yes
Diabetes or abnormal blood sugar	No	Yes	Migraine headaches	No	Yes
Epilepsy/Seizures	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Fainting or Dizzy Spells	No	Yes	Previous Biopsies	No	Yes
Glaucoma	No	Yes	Cancer or Tumor	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Radiation or Chemotherapy	No	Yes
Rheumatic Fever	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	Bone disorder (Osteoporosis/Paget's)	No	Yes
Congenital Heart Disease	No	Yes	Arthritis (Rheumatoid or osteoarthritis)	No	Yes
Angina (Chest Pains)	No	Yes	Joint Replacement? When placed?	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Slow-Healing Mouth Sores	No	Yes
Heart Stent? When placed?	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
High/Low blood pressure (circle)	No	Yes	Venereal Disease	No	Yes
Swollen ankles	No	Yes	Stomach or duodenal ulcers	No	Yes
Stroke	No	Yes	Hives or skin rashes	No	Yes
Strong family history of strokes	No	Yes	Hay fever	No	Yes
Strong family history of heart attacks	No	Yes	Psychosis/Mood disorder	No	Yes
Snoring/Sleep Apnea (circle)	No	Yes	Other Conditions not listed above?	No	Yes

Are you taking any of these medications?

Medication			Medication		
Aspirin	No	Yes	Warfarin/Coumadin	No	Yes
Plavix	No	Yes			
Pre-medication before dental treatment	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)	No	Yes
Antacids	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. ______ 2. ______
3. ______ 4. ______
5. ______ 6. ______
7. ______ 8. ______

Please list any dietary or herbal supplements you are taking, and for what purpose. Include recreational drugs (eg. marijuana)

1. ______ 2. ______
3. ______ 4. ______
5. ______ 6. ______

Women:		
Are you pregnant?	No	Yes
Is there a chance you MAY BE pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes
Have you ever had a mastectomy/cancer treatment?	No	Yes

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? ______ Today: ______/______

Pulse? ______

Are you allergic or have you had a reaction to:

a.	Local anesthetics	No	Yes
b.	Penicillin or other antibiotics	No	Yes
c.	Aspirin, Ibuprofen or Tylenol	No	Yes
d.	Codeine, Valium® or other sedatives	No	Yes
e.	Latex or Metals	No	Yes
f.	Other (please specify) ______		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you consume caffeine (coffee, teas, cola)? How often/day?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

______

Significant findings from questionnaire or oral interview:

______

Dental management considerations:

______

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of change in my health and medication.

PATIENT/GUARDIAN SIGNATURE ______ **Date** ______

DOCTOR SIGNATURE ______