HEALTH HISTORY FORM

ROCK RIVER DENTAL

_____ _____ _____ _____

PATIENT NAME *(First)* *(Middle Initial)* *(Last)* *(DOB)*

_____ _(_____)_____ _____

EMERGENCY CONTACT 1 *(Name)* *(Phone Number)* (Relationship to Patient)

_____ _(_____)_____ _____

EMERGENCY CONTACT 2 *(Name)* *(Phone Number)* (Relationship to Patient)

1) PLEASE LIST **ALL** **MEDICATIONS** UNDER COMMENTS
   (Including vitamins, birth control, supplements or controlled substances)
2) PLEASE LIST **ALL** **ALLERGIES** UNDER COMMENTS
   (Or adverse reactions to medications, anesthetics, antibiotics, latex, etc)
3) Are you under the care of a physician? (Last Physical:_____) **YES NO**
   Name of physician: _____
   Name of clinic: _____
   Date of last physical: _____
4) Are you a diabetic? **TYPE 1 TYPE 2 NO**
5) Do you have HIGH or LOW blood pressure? **HIGH LOW N/A**
6) Do you have a pacemaker, artificial heart valve, or stent?_____ **YES NO**
7) Any heart condition or disease?: _____ **YES NO**
8) Have you ever taken antibiotics before dental treatment? **YES NO**
9) Do you have any artificial joints/prosthesis?_____ **YES NO**
10) Do you have or have you had T.B. or Asthma?_____ **YES NO**
11) Do you have any blood disorders? _____ **YES NO**
12) Are you on any blood thinners? (please list under medications) **YES NO**
13) Do you have HIV, AIDS or HEPATITIS? _____ **YES NO**
14) Do you have any stomach, liver or kidney problems? _____ **YES NO**
15) Do you have any inflammatory diseases (arthritis, rheumatism)? **YES NO**
16) Do you use any form of tobacco products? _____ **YES NO**
17) Do you vape? **YES NO**
18) Are you/do you suspect you may be pregnant? **YES NO**
19) Have you ever had radiation treatment or chemotherapy? **YES NO**
20) Have you been diagnosed with obstructive sleep apnea (OSA)? **YES NO**
21) Do you use/have you tried a CPAP or other oral sleep appliance? **YES NO**
22) Do you have GERD (gastroesophageal reflux disease)? **YES NO**
23) Have you had any fainting/dizzy spells? **YES NO**
24) Do you have epilepsy or seizure disorders? _____ **YES NO**
25) Have you had psychiatric tx? **YES NO**

ANY OTHER MEDICAL ILLNESSES NOT MENTIONED? *(use back if needed)*

COMMENTS

Medications

-
-
-
-
-
-
-
-
-
-

Allergies

-
-

BP: **Date:**

_____ _____
_____ _____
_____ _____
_____ _____

Patient Review: **Date:**

_____
_____
_____

Doctor Review: **Date:**

_____
_____
_____

I certify the above information is complete and accurate.

Patient/Guardian Signature _____ *DATE* _____

Doctor Signature _____ *DATE* _____