MID BAY DENTAL
COMPREHENSIVE DENTAL WELLNESS

Health History

Name: ______________________________ Date: _______________

Do you have or have you had any of the following? Please check "YES" or "NO".

Heart Problems:

- High or Low Blood Pressure .... ○ YES ○ NO
- Heart Murmur or Mitral Valve Prolapse .... ○ YES ○ NO
- Artificial Valve, Pacemaker or Stent .... ○ YES ○ NO
- Arteriosclerosis .... ○ YES ○ NO
- Heart Attack or Angina Pectoris .... ○ YES ○ NO
- Heart Medications or Nitroglycerin .... ○ YES ○ NO

Blood Problems:

- Easy Bruising .... ○ YES ○ NO
- Abnormal Bleeding .... ○ YES ○ NO
- Blood Thinners(Coumadin, Plavix or Aspirin).. ○ YES ○ NO
- Circulatory Problems .... ○ YES ○ NO
- Hemophilia .... ○ YES ○ NO
- Low Blood Sugar or Anemia .... ○ YES ○ NO

Respiratory Problems:

- Asthma, Emphysema or Tuberculosis .... ○ YES ○ NO
- Chronic Bronchitis .... ○ YES ○ NO
- Sinus Troubles .... ○ YES ○ NO
- Frequent or Severe Headaches .... ○ YES ○ NO
- Fainting Spells, Seizures or Epilepsy .... ○ YES ○ NO

Bone or Joint Problems:

- Joint Replacement (Hip, Pins, Plates, etc) ..... ○ YES ○ NO
- Implants .... ○ YES ○ NO
- Arthritis or Osteoporosis .... ○ YES ○ NO
- Taking Bisphosphonates (Fosamax, Boniva).. ○ YES ○ NO
- Taking Corticosteroids .... ○ YES ○ NO
- Cancer (Chemotherapy or Radiation) .... ○ YES ○ NO
- Tumors or Benign Growths .... ○ YES ○ NO

Allergic Reactions:

- Aspirin, Acetaminophen, or Ibuprofen .... ○ YES ○ NO
- Codeine or Other Narcotics .... ○ YES ○ NO
- Dental Anesthetic .... ○ YES ○ NO
- Sensitivity to Epinephrine (Vasoconstrictor).. ○ YES ○ NO
- Antibiotics (Penicillin or Other) .... ○ YES ○ NO
- Sedatives (Valium) or Sleeping Pills .... ○ YES ○ NO
- Latex (Allergy or Sensitivity) .... ○ YES ○ NO

Other:

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- Diabetes .... ○ YES ○ NO
- Any Physical Limitations .... ○ YES ○ NO
- Hearing or Sight Disability .... ○ YES ○ NO
- Glaucoma or Contact Lenses .... ○ YES ○ NO
- Psychiatric Treatment .... ○ YES ○ NO
- Depression or Anxiety Disorder .... ○ YES ○ NO
- HIV or Aids .... ○ YES ○ NO
- Hepatitis A, B or C .... ○ YES ○ NO
- Liver or Kidney Issues .... ○ YES ○ NO
- Drug or Alcohol Abuse Issues .... ○ YES ○ NO
- Smoke or Chew Tobacco .... ○ YES ○ NO

Women

- Are you pregnant? .... ○ YES ○ NO
  - Taking Hormones or Contraception?....... ○ YES ○ NO

Do you require "Premedication" with an antibiotic prior to dental treatment?..... ○ YES ○ NO

- Snoring .... ○ YES ○ NO
- Sleep Apnea/ CPAP .... ○ YES ○ NO
- GERD/Acid Reflux .... ○ YES ○ NO

Medication List: