VALENCIA DENTAL OFFICE

Health History Form

Patient Information

First Name | Last Name | Date of Birth

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Responsible Party

If you are filling out this form on behalf of another person, please mention your name and your relationship with that person

Your Name | Relationship

Medical Conditions

Do you have or have you had any of the following medical conditions?

Choose *Don't Know* if you don't know or not sure of the answer to any question

Active Tuberculosis
◯ Yes ◯ No ◯ Don't know

Persistent cough greater than a 3 week duration
◯ Yes ◯ No ◯ Don't know

Cough that produces blood
◯ Yes ◯ No ◯ Don't know

Been exposed to anyone with tuberculosis
◯ Yes ◯ No ◯ Don't know

If you answered YES to any of the 4 medical conditions listed above, please stop filling out this form and contact our office.

Are you allergic to any of the following?

☐ Acrylics ☐ Antibiotics ☐ Aspirin
☐ Barbiturates ☐ Codeine ☐ Iodine
☐ Local Anesthetics ☐ Metals ☐ Penicillin
☐ Plastic ☐ Sulfa drugs ☐ Sedatives
☐ Sleeping pills ☐ Sulfa Drugs ☐ Tranquilizers
☐ No Allergies ☐ Latex

Female only Conditions

☐ Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Medical Conditions (Yes/No)

AIDS/HIV Positive
- ◯ Yes
- ◯ No

Alzheimer's Disease
- ◯ Yes
- ◯ No

Anemia
- ◯ Yes
- ◯ No

Arthritis/Gout
- ◯ Yes
- ◯ No

Artificial Joint
- ◯ Yes
- ◯ No

Asthma
- ◯ Yes
- ◯ No

Blood Disease
- ◯ Yes
- ◯ No

Breathing issues
- ◯ Yes
- ◯ No

Bruise Easily
- ◯ Yes
- ◯ No

Cancer
- ◯ Yes
- ◯ No

Chemotherapy
- ◯ Yes
- ◯ No

Cold Sores/Fever Blisters
- ◯ Yes
- ◯ No

Convulsions
- ◯ Yes
- ◯ No

Cortisone Medicine
- ◯ Yes
- ◯ No

Diabetes
- ◯ Yes
- ◯ No

Dizziness
- ◯ Yes
- ◯ No

Drug Addiction
- ◯ Yes
- ◯ No

Emphysema
- ◯ Yes
- ◯ No

Epilepsy or Seizures
- ◯ Yes
- ◯ No

Excessive Bleeding
- ◯ Yes
- ◯ No

Excessive Thirst
- ◯ Yes
- ◯ No

Frequent Cough
◯ Yes ◯ No

Frequent Headaches
◯ Yes ◯ No

Hay Fever
◯ Yes ◯ No

Head Injuries
◯ Yes ◯ No

Hearing Impairment
◯ Yes ◯ No

Hemophilia
◯ Yes ◯ No

Hepatitis A
◯ Yes ◯ No

Hepatitis B or C
◯ Yes ◯ No

Herpes
◯ Yes ◯ No

High Blood Pressure
◯ Yes ◯ No

High Cholesterol
◯ Yes ◯ No

Hives or Rash
◯ Yes ◯ No

Kidney Problems
◯ Yes ◯ No

Liver Disease
◯ Yes ◯ No

Low Blood Pressure
◯ Yes ◯ No

Lung Disease
◯ Yes ◯ No

Osteoporosis
◯ Yes ◯ No

Pain in Jaw Joints
◯ Yes ◯ No

Psychiatric Care
◯ Yes ◯ No

Radiation Treatments
◯ Yes ◯ No

Recent Weight Loss/Gain
◯ Yes ◯ No

Renal Dialysis
◯ Yes ◯ No

Scarlet Fever
- ◯ Yes
- ◯ No

Sleep Apnea
- ◯ Yes
- ◯ No

Stomach/Intestinal Disease
- ◯ Yes
- ◯ No

Stroke
- ◯ Yes
- ◯ No

Swelling of Limbs
- ◯ Yes
- ◯ No

Thyroid Disease
- ◯ Yes
- ◯ No

TMJ
- ◯ Yes
- ◯ No

Tonsillitis
- ◯ Yes
- ◯ No

Tumors or Growths
- ◯ Yes
- ◯ No

Ulcers
- ◯ Yes
- ◯ No

Vision Loss/Blindness
- ◯ Yes
- ◯ No

Do you have any of the following Cardiac conditions?
- ☐ Artificial (Prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valve transplant
- ☐ Unrepaired , Cyanotic CHD
- ☐ Repaired CHD (completely) in the last 6 months
- ☐ Repaired CHD with residual heart valve
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ Rheumatic Heart Disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Chest Pain
- ☐ Other congenital heart defects

Are you taking any prescription medications?
- ◯ Yes
- ◯ No

Please list all your medications you are currently taking and what it is for (including vitamins)

Any history of Surgeries/hospitalization? If Yes, Please explain

Do you use any tobacco or marijuana products or other controlled substances?
- ◯ Yes
- ◯ No

If yes, please explain:

Have you ever taken Fosamax(Bisphosphonate), Zometa, Actonel,Boniva or Aredia?
- ◯ Yes
- ◯ No

E-Signature (name or initials)	Date