Pulos Family Dentistry, LLC 1002 N Mitthoeffer Suite B Indianapolis IN 46229 317-898-6666

HEALTH HISTORY FORM

_____/_____/11/11/2017_____

Patient's Name Date of Birth Date

Please answer all questions by checking the box for Yes or No. All responses are kept confidential.

#	Question	YES	NO
1	Are you in good health?		
2	Has there been any change in your general health in the past year?		
3	Date of last physical exam:		
4	Are you now under a physician's care for any reason?		
5	Have you ever had any serious illnesses, operations or hospitalizations?		
	If YES, Please describe:		
6	Has your physician or surgeon ever recommended pre-medication prior to dental treatment?		
7	Height:_____ Weight:_____		
8	Do you or have you ever had the following:		
	A. Rheumatic Fever or Rheumatic Heart Disease?		
	B. Congenital Heart Disease?		
	C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)		
	D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?		
	E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?		
	F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?		
	G. Liver Disease?		
	H. Kidney Disease?		
	I. Diabetes? Most recent HbA1C:_____%		
	J. Thyroid Disease (Goiter)?		
	K. Arthritis?		
	L. Stomach Ulcers or Colitis?		
	M. Glaucoma?		
	N. Implants placed any where in your body? (for example Heart Valve, Pacemaker, Hip, Knee, Shoulder)		
	O. Radiation (X-ray) treatment for Cancer?		
	P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?		
	Q. Sinus or Nasal Problems?		
	R. Any disease, drug or transplant operation that has depressed your immune system?		
	S. Problems with mental health?		
	T. Problems with neurological disease?		
	U. Have you ever tested positive for HIV, Hepatitis B or C?		
	Most current lab values: Date: 11/11/2017		
9	Are you using any of the following:		
	A. Antibiotics?		
	B. Antidepressants?		

#	Question	YES	NO
9	C. Anticoagulants (Blood Thinners, i.e. warfarin)? INR:_____		
	D. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?		
	E. High Blood Pressure medications?		
	F. Steroids? (Cortisone, etc.)		
	G. Tranquilizers?		
	H. Insulin or Anti-Diabetic drugs?		
	I. Digitalis, Inderal, Nitroglycerin or other heart drug?		
	J. Are you taking or have you ever taken Bisphosphonates? (Fosamax, or Actonel for osteoporosis, or Chemotherapy for multiple myeloma, etc.)		
	K. Please list any and all medications taken, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins and/or minerals:		
10	Are you allergic to or have you ever had an adverse reaction to:		
	A. Local Anesthesia (Novocain, etc.)?		
	B. Penicillin or other antibiotics?		
	C. Sedatives, Barbiturates?		
	D. Aspirin or Ibuprofen?		
	E. Codeine or other pain killers?		
	F. Latex or other rubber products?		
	G. Other allergies or reactions? Please List:		
11	Do you smoke or chew Tobacco?		
12	Are there any past history events of Alcohol or Chemical Dependency or Emotional Disorders that may affect the care we care for you? (marijuana, street drugs)		
13	Have you had any serious problems associated any previous dental treatment? (excessive bleeding)		
14	Have you or an immediate family member had any problem associated intravenous anesthesia?		
15	Do you have any other disease, condition or problem not listed above that you think the doctor should know about?		
16	Do you wish to talk to the doctor privately?		
17	**FOR WOMEN ONLY**		
	A. Are you Pregnant, or is there you might be Pregnant?		
	B. Are you nursing?		
	C. lf 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 alternative 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 physician for further guidance.		

Name of person we can contact in case of an emergency:_____
Phone:_____ Cell:_____ Work:_____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature of Person Completing Health History:_____

Date:_____ Doctor's Initials:_____