Health History

WEIMERSKIRCH FAMILY DENTAL PLLC

Name: _____ Birthday: _____ Date: _____

- Do you have regular care with a medical provider? ---------- ☐ Yes ☐ No
- Are you allergic to penicillin? ---------- ☐ Yes ☐ No
- Have you had an organ transplant? ---------- ☐ Yes ☐ No
- Do you have an artificial heart valve? ---------- ☐ Yes ☐ No
- Were you born with a heart defect? ---------- ☐ Yes ☐ No
- Have you ever had endocarditis – an infection of the heart? ----- ☐ Yes ☐ No
- Have you ever taken a bisphosphonate or antiresorptive drug – sometimes used to treat low bone density or cancer? *e.g.* Reclast®, zoledronic acid, Zometa®, zolendronate, Prolia®, Xgeva®, denosumab, Boniva®, ibandronate, Fosamax®, alendronate, Revlimid®, lenalidomide, etc. ---------- ☐ Yes ☐ No
- Have you ever received radiation treatment to the head or neck? ---------- ☐ Yes ☐ No
- Are you being treated with a blood thinner or anti-coagulation drug? *e.g.* Coumadin®, warfarin, Eliquis®, apixaban, Xarelto®, rivaroxaban, Effient®, prasugrel, Plavix®, clopidogrel, etc. --------- ☐ Yes ☐ No
- Do you use tobacco? ---------- ☐ Yes ☐ No
- Do you have a personal history of cancer? ---------- ☐ Yes ☐ No
- Females: are you pregnant or nursing? ---------- ☐ Yes ☐ No

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Please check the box if you currently, or in the past, have experienced any of the following?

☐ Acid reflux
☐ Asthma, COPD, or other respiratory problems
☐ Bleeding disorders
☐ Blood disorders
☐ Chest Pain
☐ Chronic headaches
☐ Dementia or other neurological problems
☐ Heart attack
☐ Heart problems
☐ Hepatitis or other liver problems
☐ High blood pressure
☐ History of chemotherapy
☐ History of dental trauma
☐ Kidney problems
☐ Diabetes
☐ Glaucoma
☐ Neurological disorder
☐ Osteoporosis or other skeletal system disorders
☐ Radiation therapy
☐ Rheumatoid arthritis or other immune disorders
☐ Seizures
☐ Sinus problems
☐ Stroke
☐ Tuberculosis

Do you have any other drug allergies or intolerances?

☐ No ☐ Yes _____

Do you have any other health problems or is there anything else that you would like us to know about your health?

☐ No ☐ Yes _____

Do you take any medications?

☐ No If yes, please list:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____