Gateway Dental Group

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HEALTH HISTORY

Patient Name: _____ * _____ * _____ _____

Last First MI Preferred Name

Please rate your general health: *

◯ Good ◯ Fair ◯ Poor

Do you have or have you ever had active tuberculosis (TB), a persistent cough longer than 3 weeks, or a cough producing blood? *

◯ Yes ◯ No

Please select any allergies that you have: *

☐ latex ☐ local anesthetics ☐ antibiotics (please specify below) ☐ codeine

☐ ibuprofen (Advil, Motrin) ☐ acetaminophen (Tylenol) ☐ aspirin ☐ metals (please specify below)

☐ acrylic ☐ other (please specify below) ☐ I HAVE NO KNOWN ALLERGIES

Please provide additional allergy information not specified above:

_____

_____

Please select any heart conditions (or devices) that you currently have or have had in the past:

☐ heart disease ☐ heart attack ☐ angina ☐ congestive heart failure ☐ heart murmur

☐ mitral valve prolapse ☐ pacemaker ☐ defibrillator ☐ bacterial endocarditis ☐ artificial heart valve

☐ congenital heart disease ☐ high blood pressure ☐ low blood pressure

Please select any health conditions (or treatments) that you currently have or have had in the past, and provide additional specific information in the space below:

☐ stroke ☐ bleeding problem (please specify below) ☐ anemia

☐ bruise easily ☐ emphysema ☐ COPD

☐ asthma ☐ sinus problems (please specify below) ☐ kidney disease

☐ liver disease ☐ jaundice ☐ hepatitis

☐ thyroid disease ☐ parathyroid disease ☐ diabetes

☐ stomach disease ☐ intestinal disease ☐ reflux disease (GERD)

☐ digestive disorder (please specify below) ☐ cancer (please specify below) ☐ abnormal growth (please specify below)

☐ chemotherapy ☐ radiation therapy ☐ steroid therapy (e.g. prednisone)

☐ lupus ☐ rheumatoid arthritis ☐ osteoarthritis

☐ artificial joints (please specify below) ☐ muscle disease ☐ glaucoma

☐ head or neck injuries (please specify below) ☐ frequent headaches (please specify below) ☐ epilepsy, seizures, or nervous system disease

☐ mental health condition (please specify below) ☐ physical disabilities (please specify below) ☐ mental disabilities (please specify below)

☐ HIV/AIDS ☐ antibiotic therapy lasting more than 1 month ☐ organ transplant

☐ spleen removed

Please provide additional health information not specified above:

_____

_____

_____

Please list any artificial joints, implants, or devices and date(s) of placement:

Please list any surgeries in the last 5 years:

Please list any hospitalizations (and reasons) in the past 5 years:

Have you ever taken oral medication or had IV therapy for osteoporosis or high blood calcium? (e.g. Fosamax, Actonel, Boniva, Aredia, Zometa)

◯ Yes ◯ No

Please select any substances that you use:

☐ cigarettes ☐ vape/e-cigarettes ☐ alcohol ☐ smokeless tobacco ☐ medicinal marijuana ☐ illicit drugs

Please describe any current or past history of chemical addiction or substance abuse:

Are you or could you be pregnant? ◯ Yes ◯ No

If pregnant, what trimester?

◯ First ◯ Second ◯ Third

Are you nursing? ◯ Yes ◯ No

Please select any supplements you take on a regular basis:

☐ Diet or Energy supplements	☐ Multivitamin	☐ Echinacea	☐ Garlic
☐ Ginger	☐ Ginkgo	☐ Ginseng	☐ Kava
☐ St. John's Wort	☐ Valerian	☐ Vitamin E > 400 IU/day	☐ Fish Oil > 3 grams/day

Please list any dietary or herbal supplements that you take on a regular basis that are not listed above:

Please list any medications or drugs that you take:

Response Date: _____