

Susan G. GROSS DDS

Smiles For Life

Health History

Thank you for answering the following questions regarding your present and past medical condition. Your medical history and medications you take can impact your oral health and dental care. Providing this information is important so we can provide appropriate care for you. This information is kept confidential.

Name: _____

Date of birth: _____

Emergency Contact: _____ Phone# _____

Are you now under care of a physician? _____ Physicians Name: _____

Physicians Address: _____

Approximate date of last physical examination: _____

Are you in good health? _____ Have there been any changes to your general health within the past year? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ___ If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements on the attached form. List any allergies/reactions to medications, materials or food:

Please list any illness, hospitalization, surgery or accident:

Do you have or have you been treated for:

Active Tuberculosis: _____ Been exposed to anyone with Tuberculosis: _____

Have you traveled outside of the United States to a country affected by the Ebola Outbreak within the past 21 days? _____

Do you use cannabis (marijuana)? ___ Yes ___ No If yes, is it ___ medicinal? ___ recreational?

Do you use tobacco (smoking, snuff, chew, bidis), e-cigarettes, smokeless tobacco? _____

If so, are you interested in stopping _____

Have you had the human papillomavirus (HPV) vaccine series? ___ No ___ Yes If yes, when? _____

WOMEN ONLY: Are you: Pregnant?: _____ Number of Weeks: _____

Nursing?: _____ Taking birth control pills or hormone replacement therapy?: _____

Menopause?: _____

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Health History Cont.

Are you taking, have you ever taken or are you scheduled to begin taking any of the following medications used for treatment of osteoporosis and/or cancer:

- | | |
|---|--|
| <input type="checkbox"/> alendronate (Fosamax) | <input type="checkbox"/> Zometa |
| <input type="checkbox"/> risedronate (Actenol) | <input type="checkbox"/> Not currently taking any of these |
| <input type="checkbox"/> Boniva | |

Check if you currently have or have had a history of the following diseases or problems:

- | | |
|--|--|
| <input type="checkbox"/> Acid Reflux; heartburn | <input type="checkbox"/> Diabetes Type I or II |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Stress |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/ Seizures |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Headaches/ Migraines |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Cancer/ Chemotherapy/ Radiation Treatment | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Heart Bypass/ Stents |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Human papillomavirus (HPV) |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Mental health condition |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cold Sores/ Herpes Simplex | <input type="checkbox"/> Healing Complication |
| <input type="checkbox"/> Congestive heart disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis/ Jaundice |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Human papillomavirus (HPV) /oral cancer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Gastrointestinal Disease |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Jaw Pain |

Check if you currently have or have had a history of the following diseases or problems:

- | | | |
|--|---|---|
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shingles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Luekemia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Other Condition not listed |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Skin Rash/ Hives | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sleep Disorder | |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Sleep Study | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stomach Ulcer/ Disease | |
| <input type="checkbox"/> Scarlet Fever | | |

I certify that I have read and understood the above and that the information given on this form is accurate. I understand the importance of an accurate health history and that Dr. Gross and her team will rely on this information for treating me. I acknowledge that my questions, if any, have been answered to my satisfaction.

I will not hold Dr. Gross, or any other member of her staff, responsible for any action they take or do not take because of errors of admissions that I may have made in the completion of this form.

Signature _____ Date: _____

Dr. Signature _____ Date: _____

Future Visits:

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____

Date _____ Patient _____ Dr. _____ Changes _____