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?_____

Please list any allergies/reactions to medications, materials or food (add medications to form titled Medication List):_____

_____

_____

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, vapor, or 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:

- ☐ alendronate (Fosamax)
- ☐ risedronte (Actenol)
- ☐ Boniva
- ☐ Zometa
- ☐ Not currently taking any of these

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

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

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

- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually transmitted disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash/ Hives
- ☐ Sleep Disorder
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sleep Study
- ☐ Stomach Ulcer/ Disease
- ☐ Stroke
- ☐ Thyroid DIease
- ☐ Tonsillitis
- ☐ Other Condition not listed

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_____

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Date_____Patient_____Dr. _____Changes_____