MICHAEL A. LOVDA, D.D.S., LTD.

HEALTH HISTORY

PATIENT NAME____ BIRTHDATE__________

FIRST MI LAST

IT IS IMPORTANT TO TELL ALL DENTAL PERSONNEL INVOLVED IN YOUR TREATMENT ABOUT THE GENERAL STATE OF YOUR HEALTH. THIS INFORMATION IS, OF COURSE, CONFIDENTIAL

DO YOU HAVE ANY GENERAL HEALTH PROBLEMS? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN __________

HAVE YOU HAD SURGERY? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN __________

HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH WITHIN THE PAST YEAR? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN __________

HAS A PHYSICIAN EVER TOLD YOU THAT YOU NEED TO BE PREMEDICATED WITH AN ANTIBIOTIC BEFORE DENTAL TREATMENT BECAUSE OF HEART PROBLEMS, JOINT REPLACEMENT, OR ANY OTHER CONDITION? ☐ YES ☐ NO

IF YES PLEASE EXPLAIN __________

WHAT IS YOUR PHYSICIAN'S NAME? __________

CITY __________ PHONE NUMBER __________

ARE YOU TAKING ANY MEDICATIONS INCLUDING NON-PRESCRIPTION MEDICINE? ☐ YES ☐ NO

IF YES WHAT MEDICATIONS ARE YOU TAKING? __________

DO YOU TAKE ANY ASPIRIN ON A REGULAR BASIS ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU OR HAVE YOU EVER BEEN AFFLICTED WITH:

CARDIOVASCULAR DISEASE	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO
HEART TROUBLE	☐ YES	☐ NO
HEART SURGERY	☐ YES	☐ NO
PACEMAKER	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
LOW BLOOD PRESSURE	☐ YES	☐ NO
JOINT REPLACEMENT OR IMPLANT	☐ YES	☐ NO
CANCER/TUMORS	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO
EPILEPSY OR SEIZURES	☐ YES	☐ NO
HEPATITIS / TYPE ______	☐ YES	☐ NO
SINUS OR NASAL PROBLEMS	☐ YES	☐ NO
CHEMICAL DEPENDENCY	☐ YES	☐ NO
AIDS OR HIV INFECTION	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO
SEXUALLY TRANSMITTED DISEASE	☐ YES	☐ NO
BLEEDING OR CLOTTING DISORDER	☐ YES	☐ NO
HEALING COMPLICATIONS	☐ YES	☐ NO
STROKE	☐ YES	☐ NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

ASPIRIN / IBUPROFEN	☐ YES	☐ NO
CODEINE	☐ YES	☐ NO
LATEX / RUBBER	☐ YES	☐ NO
PENICILLIN OR OTHER ANTIBIOTICS	☐ YES	☐ NO
LOCAL ANESTHETICS (NOVOCAINE)	☐ YES	☐ NO

OTHER (PLEASE LIST) __________

WOMEN ONLY

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ☐ YES ☐ NO

DUE DATE __________

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR OR HIS STAFF BEFORE ADDITIONAL TREATMENT IS PERFORMED. I HAVE READ AND FULLY UNDERSTAND ALL FINANCIAL/HIPAA POLICIES WITHIN THIS HEALTH HISTORY.

SIGNATURE __________ DATE __________