Health History Update

Sarasota Center for General & Cosmetic Dentistry
Francisco J. Marcano, DMD

Date: _____
Name: _____
Male □ Female □

Street Address _____
City _____ ST _____ Zip _____
If Child: Parent Name
_____
Home Phone # _____ Cell Phone # _____ Work #_____
Number you prefer being called on □ Home □ Cell □ Work
Email_____
Occupation _____ Employer Name _____
Date of Birth _____ AGE _____
SS#_____
Person Responsible for Dental Investment
_____

For DENTAL Insurance Purposes:
Name of Insurance Company _____ Primary Insured Name _____
Primary Insured Date of Birth _____ Subscriber ID Number _____
Primary Insured Social Security Number _____
Group Number _____
Primary Insured Company Name _____ Primary Insured Zip Code _____

□ Do you have any general health problems? If so, please specify
_____
□ Have you had surgery? If so, please specify
_____
□ Are you currently under a physician's care?
Reason: _____
□ Any medications, please list:
_____
_____

Please put a check in the boxes that apply to you
Are your teeth sensitive to:
□ Heat
□ Cold
□ Sweets
□ Biting Pressure
□ Does food catch between your teeth?
□ Do your gums bleed when brushing?
□ Have you noticed any gum swelling around any teeth?
□ Do you have an unpleasant taste or order in your mouth?

□ Do your gums bleed when brushing?
□ Have you noticed any gum swelling around any teeth?

Problems of the jaw:
□ Clicking of the jaw
□ Pain (joints, ear, side of face)
□ Difficulty opening of closing
□ Difficulty chewing

□ Have you even had a bone density scan?
□ Do you ever avoid any part of the mouth while brushing?
□ Have you ever had a reaction to local Anesthetic?
□ Are you dissatisfied with your teeth and their appearance?
□ Do you smoke or chew tobacco?

□ Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? If so,

please explain
_____

□ Do you have sinus or nasal problems?
□ Lung disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain?
□ Are you taking or have you even taken: Bisphosphonates for Osteoporosis, Multiple Myeloma or other Cancers (Reclast, Fosamax, Actonal, Boniva, Aredia, Zometa)
□ Have you ever been advised NOT to take any medications? If so, which ones?
_____

To the best of your knowledge, are you or have you ever been afflicted with:
□ Diabetes
□ Rheumatic Fever
□ Glaucoma
□ Heart Aliment
□ Epilepsy
□ High Blood Pressure
□ Healing Complications
□ Respiratory Disease
□ Prolonged Bleeding
□ Shortness of Breath
□ Kidney Disease
□ Hepatitis
□ Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)

Are you **using** any of the following:
□ Antibiotics
□ Anticoagulants
□ Aspirin or drugs such as Motrin, Aleve, Ibuprofen
□ High blood pressure medications
□ Steroids (Cortisone, Prednisone)
□ Tranquilizers
□ Insulin or Oral Anti-Diabetics
□ Digitalis, Inderal, Nitroglycerin, or other heart drugs

Are you **Allergic** to or have had adverse reactions to:
□ Local Anesthesia (Novocain, Etc.)
□ Penicillin or other antibiotics
□ Codeine or other pain killers
□ Sulfa drugs
□ Aspirin or Ibuprofen
□ Latex or Rubber products
□ Metal of any kind
□ Chemicals or jewelry (rash, sensitivity)
□ Food Products
□ Any disease, drug or transplant operation that has depressed your Immune system?
□ Other allergies or reactions:
_____
_____

FOR WOMEN ONLY:

□ Are you Pregnant, or is there any chance you might be?

□ Are you Nursing?

If you are using **oral contraceptives**, it is important that you understand that Antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to used mechanical forms of birth control for one (1) complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with you physician for further guidance.

I understand the importance of a truthful and complete health history to assist my dentist in providing the best care possible. I have the opportunity to discuss my health history with my dentist.

Date _____

Signature of person completing health history _____

Doctor's Initials _____