



**DENTAL SURGEONS & IMPLANT CENTERS**  
OF FALL RIVER, DARTMOUTH, AND MIDDLEBORO

**HEALTH HISTORY FORM**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Referring Dentist \_\_\_\_\_

DATE: \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex M F  
Single: \_\_\_\_ Married: \_\_\_\_  
Name of Spouse \_\_\_\_\_

**PLEASE CIRCLE YES (Y) OR NO (N) FOR THE FOLLOWING QUESTIONS**

1. Are you in good health? Y N
2. Your last physical exam \_\_\_\_\_
3. Your primary doctor \_\_\_\_\_
4. Rheumatic fever? Y N
5. Heart murmur? Y N
6. Mitral valve prolapse? Y N
7. Congenital heart disease? Y N
8. Prosthetic heart valves Y N
9. Pacemaker/stents Y N
10. Heart attack or angina Y N
11. High blood pressure Y N
12. Chest pain Y N
13. Asthma Y N
14. Emphysema Y N
15. Bronchitis Y N
16. Tuberculosis Y N
17. Shortness of breath Y N
18. Seizures/Epilepsy Y N
19. Fainting Y N
20. Mental health/anxiety Y N
21. Depression Y N
22. Sinus problems Y N
23. Cold sores(herpes) Y N
24. Dizziness Y N
25. Stroke Y N
26. Glaucoma Y N
27. Diabetes Y N
28. Kidney disease Y N
29. Thyroid disease Y N
30. Liver disease Y N
31. Jaundice Y N
32. Hepatitis type\_\_ Y N
33. Cancer Y N
34. Radiation treatment Y N
35. Chemotherapy Y N
36. Bleeding disorder Y N  
type: \_\_\_\_\_

Please list your current medications including aspirin.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries including heart valve, joint replacement and kidney dialysis.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken any medication for osteoporosis i.e. boniva, actenol, fossamax OR reclast?

\_\_\_\_\_  
\_\_\_\_\_

Do you require premedication with antibiotics prior to dental treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature & Date

\_\_\_\_\_  
Reviewing Doctor's Signature & Date