HEARTLAND DENTAL GROUP

3507 S. 4Th St. Trfwy. * Leavenworth, Ks 66048

JANE L. CUMMINGS, PERIODONTIST
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15510 State Avenue, Ste 4 * Basehor, Ks 66007

Today's Date:_____

HEALTH HISTORY

ALL RESPONES ARE KEPT CONFIDENTIAL

Patient's Name: _____ **D.O.B.:** _____

Primary Care Physician: _____ **Physician's Phone #:** _____

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

Do you take an antibiotic premed? Y N
If so, what kind? _____
Do you play any sports or exercise? Y N
Do you have any shortness of breath with activity? Y N
Date of last physical exam: _____
Are you now under a physician's care for a particular problem? Y N
If so, please describe: _____
_____
Have you ever had a serious illness, operations or hospitalized? Y N
If so, please describe: _____
_____

DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease? Y N
B. Congenital Heart Disease? Y N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness Of Breath, Chest Pain, Severe Coughing)? Y N
E. Seizures, Convulsions, Epilepsy? Y N
F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
G. Liver Disease (Jaundice, Hepatitis)? Y N
H. Kidney Disease? Y N
I. Diabetes? Y N
Last A1C? _____ Date: _____
J. Thyroid Disease? Y N
K. Arthritis (Osteoarthritis, Rheumatoid, Psoriatic)? Y N
L. Stomach Ulcers or Colitis? Y N
M. Glaucoma? Y N
N. Osteoporosis? Y N
O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
P. Radiation (x-ray) treatment for Cancer? Y N
Q. Clicking or popping of jaw joint (TMJ), pain, difficulty Opening mouth, grind or clench teeth? Y N
R. Sinus or Nasal problems? Y N
S. Any disease, drug, or transplant operation that has depressed your immune system? Y N
T. Lupus, HIV, AIDS? Y N

ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics? Y N
B. Anticoagulants (Blood Thinners)? Y N
C. High Blood Pressure medications? Y N
D. Steroids (Cortisone, Prednisone, etc.)? Y N
E. Insulin or Oral Diabetic drugs? Y N

PAST SURGICAL HISTORY:_____
_____

Any personal history of local anesthetic complications?
Nausea/Vomiting? Y N
Prolonged Bleeding? Y N

Are you taking or have you ever taken Bisphosphonates (or monoclonal antibodies) for osteoporosis, multiple myeloma or other cancers (Rexlast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Xgeva, Denosumab)? Y N
If yes, which one? _____ Time Period?_____

Have you ever been advised to NOT take a medication? Y N
Please list all medications and DOSES for prescription medications, over the counter medications, herbs, vitamins:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local Anesthesia (Novocain, etc.)? Y N
B. Penicillin? Y N
Other antibiotics_____
C. Aspirin or Ibuprofen? Y N
D. Codeine or other pain killers? Y N
E. Latex? Y N
F. Other allergies or reactions? Please list:
_____ _____
_____ _____

Tobacco use Y N Date Quit:_____
Smokeless Tobacco Y N Date Quit:_____
Alcohol Use Y N Date Quit:_____
THC/Marijuana Y N Date Quit:_____
Other drug use Y N Date Quit:_____

Have you had any serious problems associated with any previous dental treatment? Y N
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
Do you wish to talk to the doctor privately about anything? Y N
Have you ever had a cone density scan? Y N

FOR WOMEN ONLY

A. Are you pregnant, or is there any chance you might be? Y N
B. Are you nursing? Y N
C. **If you are using oral contraceptives,** it is important that you understand the antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your 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.****

"WE CARE ABOUT THE SMILE YOU WEAR"

HEALTH HISTORY CONTINUED

Patient's Name: _____ **D.O.B.**_____ **Today's Date:** _____

Chief Dental Complaint: _____

_____

Are you under the care of a physician Y N

Primary Care Physician: _____ Phone #:_____

Cardiologist:_____ Phone #:_____

Rheumatologist:_____ Phone #:_____

Other:_____ Phone #:_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Signature: _____ **Date:**_____

Relation to Patient:_____

"WE CARE ABOUT THE SMILE YOU WEAR"

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