ROGUE VALLEY IMPLANT CENTER™

Health History Form

First:_____Last:_____DOB:_____

What is your chief complaint? _____

Please be thorough and thoughtful as you fill out your health history form. The more information regarding your whole body health the better we can tailor a customized treatment plan for you. Your overall health and safety is our #1 priority.

When was your last physical exam?_____

Are you under the care of a physician?_____

Have you had any illness, operation or been hospitalized in the past five years ?_____

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?_____

Do you have a prosthetic joint/implant?_____

Have you had a heart valve replacement or vascular graft?_____

Have you ever had general anesthesia/sedation?_____

Have you, or a family member, had any unusual reactions to sedation?_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?_____

Are you taking any blood thinners?_____

Have you ever taken diet pills?_____

Are you taking, or have you ever taken bone density medication, RANKL inhibitors or bisphosphonates, such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?_____

Is there any condition concerning your health that the doctor should be aware of?_____

_____

Do you wish to speak to the doctor privately about anything?_____

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Have you had or do you currently have?

- ☐ Rheumatic fever
- ☐ Heart valve issues
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Lower blood pressure
- ☐ Lower blood sugar
- ☐ Kidney trouble
- ☐ High cholesterol
- ☐ Are you on dialysis
- ☐ Swollen ankles
- ☐ Joint disease
- ☐ Osteoporosis / osteopenia
- ☐ Osteonecrosis
- ☐ Stomach ulcers
- ☐ Contagious disease
- ☐ Sexually transmitted disease
- ☐ Immune system issues
- ☐ Delayed healing
- ☐ Tumor / growths
- ☐ Cancer
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Fainting spells
- ☐ Gallbladder issues
- ☐ Convulsions / epilepsy
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Hepatitis / liver disease
- ☐ Steroid treatment
- ☐ Chronic fatigue
- ☐ Are you on a diet
- ☐ Alcohol use
- ☐ Drug abuse
- ☐ Smoking
- ☐ Chewing tabacco
- ☐ Vaping
- ☐ Eye disease
- ☐ Chest pain
- ☐ Chronic steroid use
- ☐ Mental health problems
- ☐ Depression
- ☐ Anxiety
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Diabetes
- ☐ Heart attack
- ☐ Irregular heart beat
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Snoring
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculous
- ☐ Emphysema
- ☐ Blood transfusions
- ☐ Other

List all medications and herbal/homeopathic supplements you take and reason for taking it.

1._____ Reason:_____

2._____ Reason:_____

3._____ Reason:_____

4._____ Reason:_____

5._____ Reason:_____

6._____ Reason:_____

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Please indicate any allergies.

- ☐ Numbing medicine
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Other antibiotics
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Sulfites
- ☐ Eggs/yolk
- ☐ Other:_____

Height:_____ Weight:_____

Doctor Notes:

I certify that I have completed this health history form to the best of my knowledge. The information written is accurate and complete. I was given opportunity to ask questions regarding this form and all questions were answered to my satisfaction.

Signautre:_____ Date:_____