Health History

(Please Print Legibly)

Rudy Paolucci DDS
COSMETIC AND GENERAL DENTISTRY FOR YOUR FAMILY

Patient Name: _____

Date of Birth: _____

Phone Number:_____

Today's Date: _____

Health Information

Personal Physician Name: _____

Personal Physician Address: _____

YES NO

❑ ❑ 1. Have you been hospitalized within the past 2 years? For what? _____

❑ ❑ 2. Are you currently being treated by a physician? For what? _____

❑ ❑ 3. Are you currently taking any medicines or drugs? What? _____

_____

❑ ❑ 4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?

❑ ❑ 5. Are you allergic to any drugs? What? _____

_____

❑ ❑ 6. Have you ever had a skin rash or other reaction to metal jewelry? To What? _____

❑ ❑ 7.Have you been told to take an antibiotic prior to dental treatment? Why?_____

❑ ❑ 8. Do you bleed excessively upon injury?

❑ ❑ 9. Are you pregnant? Due Date? _____

❑ ❑ 10. Have you ever been involved with dental/medical legal activity?

❑ ❑ 11. Are you taking or have you ever taken Bisphosphonates (Fosamax, Prolia, Boniva, Actonel, Reclast…)

❑ ❑ 12. Have you had a heart valve repair or have an artificial heart valve?

❑ ❑ 13. Have you had a joint replacement? When?_____

Circle Any of the Following Conditions That You Have Had or Now Have

A. AIDS	G. Glaucoma	M. Kidney Problems	R. Sexually Transmitted Disease
B. Arthritis	H. Heart Murmur	N. Low Blood Pressure	S. Stroke
C. Asthma	I. Heart Problem	O. Nervous Break Down	T. Tuberculosis
D. Cancer	J. Hepatitis	or Psychiatric Therapy	U. Artificial Joint
E. Diabetes	K. High Blood Pressure	P. Osteoporosis	V. Artificial Heart Valve
F. Epilepsy	L. Jaundice	Q. Rheumatic Fever	W. Neurologic Disorder

V. Other Health Concerns_____

Person to Be Contacted in Case of Emergency

Name: _____ (Relationship)_____

Telephone: _____

_____ _____

Patient Signature Relationship if other than patient