optima
DENTAL CARE

Phone# (208)773-5121 Fax# (208)777-9484
www.optimadentalcare.com

Name: _____ Birth Date: _____ Age: _____

HEALTH HISTORY
(Please circle or list)

Physician Name: _____ Phone #: _____

Have you been under the care of a medical doctor including alternative therapy in the last 2 years? Y / N

Have you been hospitalized in the past 2 years (if so for what reason)? Y / N

Have you had any operations or surgical procedures (last 5 years) ? Y / N

Have you ever been pre-medicated with antibiotics for dental work (per Physicians request)? Y / N

Do you smoke? Y / N how long? _____

Do you Chew tobacco? Y / N how long? _____

Have you at any time taken **Bisphosphonate medications** to prevent bone loss? Y / N
(such as Boniva-Fosamax)

If taking Nitro glycerin where is it located

Are you currently taking any medications **including Blood thinners**, herbals or dietary supplements? Y / N

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

MEDICAL CONDITIONS
(Please circle or list if you have, or have had any of the following)

Heart Disease	Breathing Problems	Migraine	Diabetes
Heart Attack	Asthma (what triggers it)	Fainting	Artificial Joints
Heart Failure	Sinus Trouble	Stroke	Glaucoma
Heart Murmur	Emphysema	Seizures	Thyroid Disease
Scarlet / Rheumatic Fever	Tuberculosis	Epilepsy	Drug/ Alcohol Addiction
Angina Pectoris	Kidney Trouble	Cancer	Shingles
Heart Surgery	Liver Disease	Radiation Therapy	Arthritis
Heart Pacemaker	Yellow Jaundice	Chemo Therapy	Bruise Easily
Heart Valve/Artificial	Hepatitis A B C	Cosmetic Surgery	Cold Sore/Fever Blister
High/Low Blood Pressure	Immune Disease	Hemophilia	Nervousness
A.I.D.S./ H.I.V	Blood Transfusion/ Anemia	Psychiatric Treatment	Ulcers

ALLERGIES *(Please list)*

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

***Please explain reaction that occurs ***

WOMEN *ONLY*

Are you Pregnant? Y / N

Are you taking birth control pills? Y / N

I understand that taking antibiotics may alter the effectiveness of my oral contraceptives Y / N

I understand that the information that I have given today is correct to the best of by knowledge and it is my responsibility to inform this office of any changes in my medical status. I also understand that this information will be held in the strictest confidence.

Signature: _____Date: _____ Reviewed by: _____

ASA: I II III IV WT: _____BP: _____HT: _____ Pulse: _____