Kenneth R. Winokur, DMD, PC
HEALTH HISTORY

Date:

Patient Name_____________________________________ Date of Birth: _____________

Last Dental Exam _____________ Where _________________________________ Referred By: ____________________________

Primary Care Doctor_________________________ Phone___________________

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ....Y N
2. Has there been any change in your general health in the past year?....................................Y N
3. Date of last physical exam ___________________________
4. Are you now under a physician's care for a particular problem? ....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ....Y N
   ____
   ____
6. Height _____ Weight ______
7. **DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CIRCLE WHICH CONDITION APPLIES FOR YES ANSWERS)**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease?....................................Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur (Mitral Valve Prolapse, Rheumatic fever), Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain?...........................Y N
   - E. Obstructive Sleep Apnea, C-PAP ....Y N
   - F. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ....Y N
   - G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............Y N
   - H. Liver Disease (Jaundice, Hepatitis)?.......................Y N
   - I. Kidney Disease?...Y N
   - J. Diabetes?...Y N
   - K. Thyroid Disease (Goiter)?.......................................Y N
   - L. Arthritis?..Y N
   - M. Stomach Ulcers or Colitis?.....................................Y N
   - N. Glaucoma? ....Y N
   - O. Implants or artificial joints 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, pain near ear, 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
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ....Y N
   - B. Anticoagulants (Blood Thinners)?...........................Y N
   - C. Aspirin or drugs such as Aleve, Ibuprofen? ....Y N
   - D. High Blood Pressure medications?.........................Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ....Y N
   - F. Tranquilizers? ....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N

All responses are kept confidential

- I. Have you ever been given Prolia, Xgeva, or Avastin? .... Y N
- J. Have you ever taken a Bisphosphonate (Aredia, Zometa, Actonel, Boniva, Fosamax, Skelid, Didronel) ....Y N
- K. Have you ever had a Bisphosphonate Reclast Injection?... Y N
- L. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins, recreational drugs or minerals:______________________________________
  ____
  ____
  ____

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

- A. Local Anesthesia (Novocain, etc.)?........................ Y N
- B. Penicillin or other antibiotics?................................ Y N
- C. Sedatives, Barbiturates, Sulfites? .... Y N
- D. Aspirin or Ibuprofen?... Y N
- E. Codeine or other pain killers?................................ Y N
- F. Latex or Rubber Products? .... Y N
- G. Eggs or Soybeans?...Y N
- H. Other allergies or reactions? Please, list.............. Y N
  ____

10. Do you smoke or chew Tobacco? .... Y N
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Do you use recreational drugs? List Above…………...…Y N
13. Have you had any serious problems associated with any previous dental treatment? .... Y N
14. Have you or an immediate family member had any problem associated with anesthesia?........................... Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
16. Do you wish to talk to the doctor privately about anything?.. Y N
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
    - B. Are you nursing? .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that 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 Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

______________________ ______________________________________ ______________________

Date | Signature of Person Completing Health History | RDH/DMD Initials