RALPH W ALMAN, JR, DDS, PA

Dental Implants ✦ Oral Maxillofacial Surgery

Date: ___________

HEALTH HISTORY FORM – page 1 of 2

GENERAL HEALTH: Height: __________ Weight: ___________

☐Y ☐N Do you see a medical doctor for any reason other than annual routine visits?
☐Y ☐N Are you under the care of a physician? Name: _________________________ #:_________________
☐Y ☐N Have you had an illness, operation, or been hospitalized in the past 5 years? ___________________
☐Y ☐N Do you need to take antibiotics prior to having dental care?
Please provide your Pharmacy Name & #: ____

CONDITIONS: For each Yes please note beside or at the bottom line any details.

HEART & CIRCULATORY:

☐Y ☐N High/Low Blood Pressure	☐Y ☐N Heart Surgery
☐Y ☐N Blood Transfusion	☐Y ☐N Heart Murmur/ Mitral Valve Prolapse
☐Y ☐N Cardiac Pacemaker	☐Y ☐N Heart Valve Problem
☐Y ☐N Chest Pain / Angina	☐Y ☐N Bleeding Tendency / Abnormal Bleeding
☐Y ☐N Irregular Heartbeat	☐Y ☐N Frequent Nosebleeds
☐Y ☐N Heart Attack(s)	☐Y ☐N Blood Disorder Such As Anemia (any kind)
☐Y ☐N Bruise Easily	☐Y ☐N HIV-positive / AIDS / Hepatitis
☐Y ☐N Artificial Heart Valve	☐Y ☐N Rheumatic Fever

RESPIRATORY:

☐Y ☐N Asthma	☐Y ☐N Smoke ☐ Past ☐ Current __ Pk/Day or ☐ Other Products
☐Y ☐N Shortness of Breath	☐Y ☐N Bronchitis / Chronic Cough / Emphysema
☐Y ☐N Sleep Apnea	☐Y ☐N Hay Fever / Sinus Problems
☐Y ☐N Tuberculosis /Other Lung Diseases	☐Y ☐N Difficult Breathing/ Other Lung Problems

OTHER:

☐Y ☐N History of Drug or Alcohol Abuse	☐Y ☐N Thyroid Problems
☐Y ☐N Immune System Problems	☐Y ☐N Swollen Ankles, Arthritis, or Joint Disease
☐Y ☐N Difficulty Opening Mouth	☐Y ☐N Chronic Fatigue / Night Sweats
☐Y ☐N Sexually Transmitted Diseases	☐Y ☐N Fainting / Convulsions / Epilepsy / Seizures
☐Y ☐N Stroke(s)/Neurological Disease	☐Y ☐N Eye Disease / Glaucoma
☐Y ☐N Mental Health Problems	☐Y ☐N Diabetes? Last Test:______ Reading:_______ ☐ Family History
☐Y ☐N Kidney Problems / Dialysis	☐Y ☐N Prosthetic Joint(s) Where: __________________
☐Y ☐N Weight ☐ Loss or ☐ Gain	☐Y ☐N Hepatitis / Jaundice / Liver Disease or Problems
☐Y ☐N Oral or Facial Piercing	☐Y ☐N TMJ /Pain or Clicking of Jaw(s) When Eating
☐Y ☐N Removable Denture or Plate	☐Y ☐N Problems w/ General Anesthesia or family
☐Y ☐N Stomach Ulcers	☐Y ☐N Urinate more than 6 Times Per Day
☐Y ☐N Arthritis	☐Y ☐N Cancer/Tumor (or Growth) / Chemo When:_____________
☐Y ☐N Gall Bladder Problems	☐Y ☐N Frequent or Severe Headaches
☐Y ☐N Malignant Hyperthermia	☐Y ☐N Low Blood Sugar

☐Y ☐N Do you have a disease, condition, or problem not listed previously that you feel we should know about?

Describe:____

SIGNATURE: Page 1 of 2

I understand the information I provide on this form is essential to determine my dental needs & the provision of treatment. I understand that if any changes occur in my health, I will report it as soon as possible. I have read & understand the questions and answered them truthfully and to the best of my ability. I have had the opportunity to discuss my health history with Dr. Alman.

_______________________________________ ____________
Signature (☐ Patient ☐ Parent ☐ Legal Guardian) Date:

_______________________________________ ____________
Dr. Ralph Alman, Jr. Date:

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HEALTH HISTORY FORM – page 2 of 2

WOMEN ONLY:

☐Y ☐N Are you or is it possible you are pregnant? If Yes: What Trimester Are You In? __ ☐Y ☐N Are you nursing?
☐Y ☐N Do you take birth control or hormone replacement therapy(HRT)?

ALLERGIES & REACTIONS:

☐Y ☐N Are you allergic to or have had an adverse reaction to the following?

Please note the reaction – Rash, Hives, Itching, Swelling, Wheezing, or any other symptom

		Reaction:			Reaction:
Penicillin	☐Y ☐N	________________	Aspirin, Acetaminophen, Ibuprofen	☐Y ☐N	________________
Other Antibiotics (Sulfa)	☐Y ☐N	________________	Codeine, Demerol, Other Narcotics	☐Y ☐N	________________
Local Anesthetics	☐Y ☐N	________________	Barbiturates, Sedatives/Sleeping Pills	☐Y ☐N	________________
Aspirin	☐Y ☐N	________________	Egg Yolks or Soy Beans	☐Y ☐N	________________
Latex or Rubber Dams	☐Y ☐N	________________	Adhesive Tapes or Bandages	☐Y ☐N	________________
Metals	☐Y ☐N	________________	OTHER: ______________________		________________

MEDICATIONS:

☐ None of the below apply.

Current & Last 12 Months	Medication & Dosage:	Current & Last 12 Months	Medication & Dosage:
☐Y ☐N ☐12	Blood Thinners/Anticoagulants: __________________________	☐Y ☐N ☐12	Antibiotics: ____
☐Y ☐N ☐12	Aspirin (including baby)	☐Y ☐N ☐12	Steroids such as Prednisone (cortisone): ____
☐Y ☐N ☐12	Allergy Medication(s): ___________________________	☐Y ☐N ☐12	Medication(s) for Osteoporosis (Bone Density) ______________________________ Last Taken: __________
☐Y ☐N ☐12	Tranquilizer(s): ___________________________	☐Y ☐N ☐12	High Blood Pressure Medication: ____
☐Y ☐N ☐12	Insulin/Drug(s) for Blood Sugar: ___________________________	☐Y ☐N ☐12	Digitalis or Drugs for Heart Conditions: ____
☐Y ☐N ☐12	Nitroglycerin	☐Y ☐N ☐12	Natural/Herbal Remedies: ____
☐Y ☐N ☐12	Other: PLEASE DETAIL BELOW	☐Y ☐N ☐12	Nonprescription Drugs/Supplements (i.e. Diet Supplements): ____

☐ See Attached List (If you have a have a list of medications we are pleased to make a copy to attach):

Medication(s):	What Med is For:	Dose & Frequency:	Medical Doctor Prescribing:
____________________	______________	_________________	____
____________________	______________	_________________	____
____________________	______________	_________________	____
____________________	______________	_________________	____
____________________	______________	_________________	____

Other: Activities

☐Y ☐N Do you have plans to ☐ travel and/or ☐ fly soon? Details: ____
☐Y ☐N ☐ Athlete ☐ Swimmer
☐Y ☐N ☐ Play a Wind Instrument ☐ Singer

SIGNATURE: Page 2 of 2

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____ ____________
Signature (☐ Patient ☐ Parent ☐ Legal Guardian) Date:

____ ____________
Dr. Ralph Alman, Jr. Date: