

Ann Marie Hofbauer, DMD
 2260 SW 2nd ST, McMinnville, Oregon 97128
 phone 503.474.9888 fax 503.474.9889

HEALTH HISTORY

Name: _____ Date: _____

Age: _____ DOB: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last five years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes Type 1 or 11	No	Yes	Previous Biopsies	No	Yes
<i>If diabetic, last HBA1C</i>			Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Epilepsy	No	Yes
Veneral Disease	No	Yes	Latex Sensitivity	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Do you feel nervous or uneasy about having dental treatment? No Yes

Women:

Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Abnormal Blood Pressure? No Yes
 If yes, what is it usually? _____

Have you had previous Orthodontic care? No Yes

Have you had your wisdom teeth extracted? No Yes
 If yes, when? _____

Can you climb a flight of stairs? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics	No	Yes
b. Penicillin or other antibiotics	No	Yes
c. Aspirin.	No	Yes
d. Codeine, valium or other sedatives.....	No	Yes
e. Iodine/Shellfish.....	No	Yes
f. Other _____	No	Yes

Tobacco use:
 Smoker? No Yes Chew? No Yes
 If yes, how much do you smoke/chew per day? _____

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Have you previously been treated with any of the following Bisphosphonate drugs:

Oral: Fosamax, Boniva, Didronel, or Actonel

IV drugs: Aredia or Zmeta

If yes, which ones? _____ dose/length of time _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes

If yes, which ones? _____

Weight: _____

PHARMACY OF CHOICE: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Hofbauer's office of changes in my health and medication.

 Patient Signature

 Print Patient Name

 Date