

**Independence Dental**  
**Kenneth R. Winokur, DMD, PC**  
 HEALTH HISTORY  
 ALL INFORMATION IS KEPT CONFIDENTIAL

Patient Name: \_\_\_\_\_ Referred By: \_\_\_\_\_

Birthdate: \_\_\_\_\_

When was your last dental exam? \_\_\_\_\_ Where? \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Primary Care Phone: \_\_\_\_\_

Answer all questions by checking 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. When did you last see your doctor? \_\_\_\_\_
4. Are you now under a physician's care for a particular problem?..... Y  N   
If yes, describe: \_\_\_\_\_
5. Have you ever had any serious illnesses, operations, hospitalizations?..... Y  N   
If yes, describe: \_\_\_\_\_
6. **DO YOU HAVE OR HAVE YOU HAD:**
  - Rheumatic Fever or Rheumatic Heart Disease?.. Y  N
  - Congenital Heart Disease?..... Y  N
  - Cardiovascular Disease (heart attack, angina, heart trouble, heart murmur, coronary artery disease attack, heart palpitations, heart surgery, pacemaker?..... Y  N
  - Stroke? ..... Y  N
  - High blood pressure? ..... Y  N
  - Lung Disease: Asthma, Chronic Cough, Bronchitis, Pneumonia? ..... Y  N
  - Tuberculosis ..... Y  N
  - Shortness of Breath ..... Y  N
  - Chest pain ..... Y  N
  - Seizures, Convulsions, Epilepsy..... Y  N
  - Fainting or Dizziness ..... Y  N
  - Bleeding disorder, anemia, blood transfusion or bleeding tendencies?..... Y  N
  - Do you bruise easily? ..... Y  N
  - Liver Disease (jaundice or hepatitis)..... Y  N
  - Diabetes..... Y  N
  - Kidney Disease ..... Y  N
  - Thyroid Disease (goiter) ..... Y  N
  - Arthritis ..... Y  N
  - Stomach Ulcers or Colitis..... Y  N
  - Glaucoma..... Y  N
  - Sinus or Nasal problems?..... Y  N
  - Radiation (XRay) treatment for cancer?..... Y  N
  - Any diseases, drug or transplant operation that has depressed your immune system?..... Y  N
  - Implants or artificial joint placed anywhere in your body (heart valve, pacemaker, hip, knee)? ..... Y  N   
If yes, when: \_\_\_\_\_
  - Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y  N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
  - Antibiotics?..... Y  N
  - Anticoagulants (Blood thinners)?..... Y  N
  - Aspirin or drugs such as Aleve, Ibuprofen? ..... Y  N
  - High Blood Pressure medications?..... Y  N
  - Steroids (Cortisone, Prednizone, etc.?) ..... Y  N
  - Tranquilizers?..... Y  N
  - Insulin or Oral Anti-Diabetic drugs? ..... Y  N
  - Digitalis, Inderal, Nitroglycerin or other heart drug? Y  N
  - Bisphosphonate (Aredia, Zometa, Actonel, Boniva, Fosamax, Skelid, Didronel)? ..... Y  N
  - PLEASE LIST any and all medications taken, including prescription medication, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
 

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____
  - MEN ONLY: Male enhancement drug?..... Y  N
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
  - Local Anesthesia (Novacaine, etc.)? ..... Y  N
  - Penicillin or other antibiotics? ..... Y  N
  - Sedatives, Barbituates, Sulfites? ..... Y  N
  - Aspirin or Ibuprofen? ..... Y  N
  - Codeine or other pain killers? ..... Y  N
  - Latex or Rubber Products? ..... Y  N
  - Other allergies or reactions?..... Y  N   
If yes, please list \_\_\_\_\_
9. Do you smoke or chew Tobacco? ..... Y  N   
If yes, how much per day? \_\_\_\_\_  
How many years? \_\_\_\_\_
10. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Y  N
11. Do you use recreational drugs? ..... Y  N   
If yes, please list: \_\_\_\_\_
12. Have you or an immediate family member had any problem associated with anesthetic? ..... Y  N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y  N
14. Have you had or currently have any (STD) sexually transmitted diseases? ..... Y  N
15. Do you wish to talk to the doctor privately about anything? ..... Y  N
16. **WOMEN ONLY:**
  - Are you Pregnant, or is there any chance you might be pregnant? ..... Y  N
  - Are you nursing? ..... Y  N
  - 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 medical physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Completing Health History

\_\_\_\_\_  
RDH/DMD Initials