Boylston Street Dental Group

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CONFIDENTIAL Health History

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

Are you under the care of a physician? * ◯ Yes ◯ No

Physician Name and Phone Number:

_____

_____

Have you ever been treated for any of the following medical conditions?

- ☐ *Pre-Med - Amox
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Blood Diseases
- ☐ Chest Pain/Angina
- ☐ Diabetes
- ☐ Food Dye
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ PDD
- ☐ Respiratory Problems
- ☐ Sickle Cell Disease
- ☐ STD's or Cold Sores
- ☐ Tuberculosis
- ☐ *Pre-Med - Clind
- ☐ Artficial HeartValve
- ☐ Atrial Fibrillation
- ☐ Blood thinners
- ☐ Chronic Fatigue Synd
- ☐ Emotional Problems
- ☐ Fosamax
- ☐ Gluten
- ☐ Heart Murmur/MVP
- ☐ HIV
- ☐ Learning Disability
- ☐ No Epinephrine
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tumors
- ☐ ADHD
- ☐ Arthritis
- ☐ Autism
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Hearing Impaired
- ☐ Hepatitis
- ☐ Hypoglycemic
- ☐ Leukemia
- ☐ Organ Transplant
- ☐ Radiation Treatment
- ☐ Seasonal Allergies
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ z OTHER-SEE MED HX
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Autoimmune Disease
- ☐ Cerebral Palsy
- ☐ Developmental Issue
- ☐ Food Dye
- ☐ GERD/Acid Reflux
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Reclast
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Thyroid Problems

Do you have or have you ever had any of the following conditions? *

- ☐ Prosthetic cardiac valve
- ☐ Cardiac transplantation recipients who develop cardiac valvulopathy
- ☐ Previous infective endocarditis (IE)
- ☐ NONE OF THE ABOVE

Have you ever had any of the following Congenital Heart Disease (CHD) conditions? *

- ☐ Unrepaired cyanotic CHD
- ☐ Palliative shunts and conduits
- ☐ Completely repaired congenital heart defects with prosthetic material or device, whether placed by surgery, or catheter intervention, during the first 6 months after the procedure
- ☐ Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibits endothelialization)
- ☐ NO HISTORY OF CONGENITAL HEART DISEASE

Please list any other serious medical condition(s) not listed above that you have been treated for: *

_____

_____

Do you have or have you ever been allergic to any of the following:

- [ ] Amoxicillin
- [ ] Apple
- [ ] Aspirin
- [ ] Augmentin
- [ ] Beans
- [ ] Carrot
- [ ] Ceftriaxone
- [ ] Cephalospori
- [ ] Clindamycin
- [ ] Codeine
- [ ] Corn
- [ ] Dairy
- [ ] Egg
- [ ] Erythromycin
- [ ] Fentanyl
- [ ] Food Dye
- [ ] Gluten
- [ ] Keflex
- [ ] Latex
- [ ] Lentil
- [ ] Local Anesthetic
- [ ] Mango
- [ ] Morphine
- [ ] mushrooms
- [ ] Nut Allergy
- [ ] Nystatin
- [ ] Papaya
- [ ] Peanut
- [ ] Peas
- [ ] Penicillin
- [ ] Seafood/fish
- [ ] Sesame
- [ ] Soy
- [ ] Strawberry
- [ ] Sulfa/Bactrim
- [ ] Tomato
- [ ] Tree Nut
- [ ] Walnut
- [ ] Zithromax

Please list any other allergies not listed above:

Do you smoke? * ◯ Yes ◯ No

Do you use chewing tobacco? * ◯ Yes ◯ No

Medications

Please check all that apply: *

- [ ] Actonel
- [ ] Adderall
- [ ] Albuterol
- [ ] Allegra
- [ ] Aspirin - 325 mg+/daily
- [ ] Aspirin - 81 mg/daily
- [ ] Atenolol
- [ ] Birth Control
- [ ] Blood thinners
- [ ] Celebrex
- [ ] Celexa
- [ ] Citalopram
- [ ] Claritin
- [ ] Coumadin/Warfarin
- [ ] Crestor
- [ ] Cymbalta
- [ ] Dilantin
- [ ] Effexor
- [ ] Flomax
- [ ] Flovent HFA
- [ ] Fosamax
- [ ] Glipizide
- [ ] Hydrochlorothiazide
- [ ] Insulin
- [ ] Lexapro
- [ ] Lipitor
- [ ] Lisinopril
- [ ] Metformin
- [ ] Nitroglycerin
- [ ] Paxil
- [ ] Pepcid/Famotidine
- [ ] Plavix
- [ ] Prilosec/Omeprazole
- [ ] Prolia
- [ ] Propranolol
- [ ] Prozac
- [ ] Pulmicort
- [ ] Reclast
- [ ] Ritalin
- [ ] Singulair
- [ ] Statins
- [ ] Synthroid
- [ ] Trazodone
- [ ] Wellbutrin
- [ ] Xyzal
- [ ] Zantac/Ranitidine
- [ ] Zoloft
- [ ] Zyrtec
- [ ] OTHER - List Below
- [ ] NOT TAKING MEDS

Are you presently taking any prescription or over the counter medications? *

Are you taking any herbal supplements? *

Have you ever been treated for osteoporosis, Paget's disease, bone pain, multiple myeloma, or metastatic cancer? Have you ever had bisphosphonate treatment such as Fosamax, Boniva, Reclast, Actonel, Atelvia? If yes, please explain and list any associated medications/treatments. *

Does your physician want you to take an antibiotic prior to your dental visits for any of the following conditions: Heart murmur, mitral valve prolapse, organ transplant, joint or valve replacement? *

◯ Yes ◯ No

If yes, what were you prescribed?

_____

_____

☐ * **By checking this box, I certify that I have read and I understand the questions on this form. I will not hold my dentist or any staff member of this office responsible for any errors or omissions that I have made in the completion of this form.**

Enter your name and relationship to patient, if applicable, as your digital signature: *

_____

_____

☐ * **By checking this box, I acknowledge that my name listed above is my digital signature.**

Response Date: ____/____/_____