Coonen Dental
3060 Cabernet Dr. Ste #1, Helena, MT 59601
Phone: (406) 442-3190

Health History

To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential. Thank You

Today's Date:_____

Name:_____ Date of Birth:_____
Physician's Name:_____ Address:_____
Physician's Phone:_____ _____
_____
Most recent visit to physician?_____ Reason:_____

(Please Circle One)

Do we have your permission to consult with your physician? YES NO
Are you currently seeing a physician for treatment of a recent or ongoing medical condition? YES NO
If yes, for what condition:_____
When was your last complete physical including bloods tests?_____
Have you been hospitalized or had a serious illness within the last year? YES NO
If yes, please explain:_____
Have you ever been advised to take antibiotics before a dental appointment? YES NO
If yes, please explain:_____
Have you had any serious medical trouble associated with any dental experience? YES NO
If yes, please explain:_____

PLEASE MARK ANY PAST OR CURRENT CONDITIONS:

Jaw Joint Pain	YES	NO	Impaired Eyesight/Glaucoma	YES	NO
Arthritis	YES	NO	Hearing Aid/Hearing Disorder	YES	NO
Venereal disease	YES	NO	Kidney Condition: Shunt/ Dialysis	YES	NO
Epilepsy/seizures	YES	NO	Frequent Mouth Sores or Lesions	YES	NO
Ulcers	YES	NO	Positive HIV; AIDS ;AIDS related complex	YES	NO
Osteoporosis/osteopenia	YES	NO	Autoimmune disorder	YES	NO
Organ transplant	YES	NO	Parkinson's Disease	YES	NO
Depression/Anxiety	YES	NO	Drug/Alcohol addiction	YES	NO
Severe Headaches/Migraines	YES	NO	Steroid (prednisone cortisone) Therapy	YES	NO

Artificial Joint(s) YES NO
If yes, which joint(s):_____Date of Replacement(s)?_____
Liver Condition YES NO
If yes, Indicate condition(s) (circle) Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific
Cancer YES NO
If yes, type:_____
Treatment **(circle all that apply)** Surgical Chemotherapy Radiation

Endocrine:

Thyroid Disease YES NO
Diabetes: YES NO
If yes, complete the following: Your last Hemoglobin A1c:_____
(circle) *Type I Type II* How often do you have HbA1c tested? 3mo 6mo 12mo
Do you require Insulin? YES NO How often do you check your blood sugar?_____

Circulation:

Arterio/atherosclerosis	YES	NO	Heart Surgery: **(circle)** Bi-pass, Valve, Other	YES	NO
High Cholesterol	YES	NO	Rheumatic Fever; Rheumatic Heart Disease	YES	NO
High/Low Blood Pressure	YES	NO	Pacemaker If yes, date placed:_____	YES	NO
Mitral Valve Prolapse	YES	NO	Heart Attack(s) If yes, date:_____	YES	NO
Heart Murmur	YES	NO	Stroke	YES	NO
Angina (chest pain)	YES	NO	Blood/Bleeding disorder	YES	NO
Congestive Heart Failure	YES	NO	Congenital Heart Defect	YES	NO

Respiratory:

Chronic Lung Disease	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Ever Exposed to TB	YES	NO
Hay Fever/Allergies	YES	NO	Persistent Cough or Cough up Blood	YES	NO
Emphysema	YES	NO	Chronic Sinus	YES	NO

Current Use of Tobacco YES NO

If Yes, type: (circle) Cigarettes Snuff/Chew Cigar Pipe

If yes, How much per day_____Years of Use_____

Past history of Tobacco Use? YES NO If yes, when quit _____

Allergies:

If allergic or have had previous reactions to the following **(Circle any/all that apply)**

Aspirin Penicillin Tetracycline Erythromycin Sulfa Latex Codeine Barbiturates Tranquilizers Dental anesthetic Other:_____

Have you ever had an adverse reaction (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any medicine? YES NO If yes, please explain:_____

_____

Do you have any medical problem condition not listed that you feel we should know about? YES NO

If yes, explain_____

Woman Only:

Are you currently pregnant:	YES	NO	If yes, expected delivery date:_____		
Are you nursing:	YES	NO	Are you going or gone through menopause	YES	NO

Sleep:

Please circle your condition, using Epworth's 0-3 Sleepiness Scale, during the following activities

0 = Would never do 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactively in a public place	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch w/o alcohol	0	1	2	3
8. Driving a car stopped in traffic or at a stop light	0	1	2	3

9. Have you ever been told you snore? YES NO
10. Do you wake up tired or fatigued? YES NO
11. Do you have morning tension / migraine headaches YES NO
12. Have you been diagnosed with:
    Chronic Fatigue Syndrome, Irritable Bowel Syndrome, Fibromyalgia, Temporomandibular Syndrome
13. Any additional comments that may be helpful?

Are you currently receiving **intravenous** Bisphosphonates? YES NO

If yes, for how long:_____

Are you currently taking **oral** Bisphosphonates (Fosamax, Actonel, Boniva)? YES NO

If yes for how long:_____

Have you been treated with this type of medication in the past? YES NO

Herbal Medications/Supplements/Prescriptions:

Are you taking any of the following herbal medications supplements? **(Circle any/all that apply)**

Echinacea	Licorice	Ginseng	Ephedra/Ma huang	Garlic/ajo	St. John's Wort
Ginkgo	Valerian	Ginger	Feverfew	Coenzyme/Q10	Goldenseal
Saw Palmetto					

Please list all: Prescription medications, herbal medications (other than indicated above) & vitamins or supplements that you are currently taking.

Name of medication	Dosage	Condition/Reason you are taking