Health History – Kenneth S. Roll, DDS
All responses are kept confidential. If you do not understand a question, please ask for help

PLEASE ANSWER ALL QUESTIONS YES (Y) OR NO (N)

1. Are you in good health? . . .Y N
   a.) weight?________ b.) height?_________________
2. Has there been **ANY** change in your general health in the past year . .. .Y N

3. Date of last physical exam?____________________

4. Are you now under a physician's care for a particular problem . . . .Y N
   ___ / ___
   Name of Physician phone #
5. Have you had any serious illness, operations or hospitalization? If so, describe . Y N
   ____
6. Have you had any adverse effects from dental treatment? . . . . .Y N

7. Do you have or have you ever had:
   - A. Rheumatic fever or rheumatic heart disease? .Y N
   - B. Congenital heart disease . . .Y N
   - C. Cardiovascular disease(heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? . . .Y N
   - D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, sever coughing. .Y N
   - E. Seizures, convulsions, epilepsy, seizures, fainting Psychiatric treatment, dizziness, nervous disorder or breakdown?. . . . .Y N
   - F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, do you bruise easily?. .Y N
   - G. Liver disease (jaundice, hepatitis)?. . .Y N
   - H. Urinary tract or kidney disease?. . .Y N
   - I. Diabetes?. . . . .Y N
   - J. Thyroid disease?. . . . .Y N
   - K. Arthritis?. . . . .Y N
   - L. Stomach ulcers or colitis?. . . .Y N
   - M. Glaucoma?. . . . .Y N
   - N. Frequent or recurring mouth sores. . .Y N
   - O. Implants placed **anywhere** in your body (heart valve, hip, knee, etc)?. . . .Y N
   - P. Radiation (X-ray) treatment for cancer?. .Y N
     P. Radiation (X-ray) treatment for cancer? Cancer Chemotherapy. . . .Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?. .Y N
   - R. Sinus or nasal problems. . . .Y N
   - S. Any disease, drugs or transplant operation that has depressed your immune system?. . .Y N
   - T. Recurrent infection of any kind?. . .Y N
   - U. Do you have any numbness or tingling sensation in any part of your body?. . .Y N
   - V. Have you ever had an injury to your face or fracture of your jaw?. . . .Y N
   - W. Have you ever had a head/spinal injury. .Y N
   - X. Do you take or have you ever taken: Bisphosphonates, such as: Aredia, Zometa, Bonefos, Actonel, Boniva, Fosamax, Skelid, Didronel, Reclast. (please circle)

8. Are you using or taking any of the following:
   - A. Zantac, Pepcid, antacids?. . . .Y N
   - B. Thyroid medications?. . . .Y N
   - C. Antibiotics or sulfa drugs?. . . .Y N
   - D. Anticoagulants (blood thinners)?. . .Y N
   - E. High blood pressure medication?. . .Y N
   - F. Steroids (Cortisone, etc.). . . .Y N
   - G. Tranquilizers (Valium, etc.). . . .Y N
   - H. Insulin, Glucophage, or similar drug?. . .Y N
   - I. Digitalis, Inderal, Nitroglycerin, calcium channel blockers, procardia or other heart medicine. . . .Y N
   - J. Aspirin or Ibuprofen (Motrin, Naprosyn, etc?). .Y N
   - K. Marijuana or other "street" drugs?. . .Y N
   - L. Antihistamine or decongestants (Seldane?). .Y N
   - M. Are you taking any other regular medications, pills, or drugs including homeopathic remedies.?. .Y N
     Please list your current medications with frequency & dosage
     ____
     ____
     ____
9. Are you allergic or had a bad reaction to:
   - A. Local Anesthetic (Novocaine, etc.)?. . .Y N
   - B. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics? (Please Circle). . . .Y N
   - C. Barbiturates, sedatives, etc.?. . . .Y N
   - D. Aspirin or Ibuprobfen?. . . .Y N
   - E. Codeine or other pain killers?. . .Y N
   - F. Latex or rubber products?. . . .Y N
   - G. Other Allergies or reactions?. . .Y N
     If yes, please list:______________________________
     ____
10. Do you smoke or chew tobacco?. . Y N
11. Do you use alcohol?.. . . Y N
12. Do you wear contact lenses?. . . Y N

13. For Women Only **A.** If you are using oral contraceptives it is important that you understand that antibiotics and 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 medications is completed. Please consult with your physician for further guidance.
B. If you are pregnant, **possibly** pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise the doctor of there is **any** chance of your being pregnant! **C.** Are you pregnant? ____ **D.** How many Months?____ **.** Are you nursing ?_____ **F.** Do you wish to have a pregnancy test?...Y N
G. Date of Last Menstrual Period_______________

14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?. . . .Y N
15. Do you wish to talk with the doctor privately about anything?. . . . .Y N

To the best of my knowledge, the above information is complete and is correct. I, the undersigned, herewith give Dr. Kenneth S. Roll, or associates, permission to secure x-rays and to perform whatever diagnostic procedures are necessary for determination of a treatment plan.

_____ / _____ / _____ / _____
Date | Signature of person completing health history (parent or guardian if patient is a minor) | Reviewed w / patient by Doctor's Initials | Date

Medical Update: I have read my health history date__________ and confirm that it adequately states my past and present conditions.

____
Date | Exceptions or Changes to health | Patient's Signature | Doctor's Initials