



Cassity Implants & Periodontics

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HEALTH HISTORY

(Please Print)

Name _____ Age _____ Date of Birth _____

DENTAL

- Name of referring dentist or person _____
- Are you having pain or discomfort at this time? Yes No
- Do you have any present dental complaints (bleeding gums, loose teeth, etc.)? Yes No
If so, explain _____
- Have you ever had an unusual reaction to dental anesthetic? Yes No
- If you have or ever have had the following, check the box:

<input type="checkbox"/> Cold or Canker sores	<input type="checkbox"/> Injury to face, jaw or teeth
<input type="checkbox"/> Sensitivity to biting or pressure	<input type="checkbox"/> Clenching or grinding teeth
<input type="checkbox"/> Sensitivity to hot, cold or sweets	<input type="checkbox"/> Periodontal (gum) treatment
<input type="checkbox"/> Food trapped between teeth	<input type="checkbox"/> Orthodontic treatment (braces)
<input type="checkbox"/> Pain, clicking, or popping of jaw	<input type="checkbox"/> Chronic Snoring
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Frequent day time sleepiness
- Any other dental condition not mentioned above: _____

MEDICAL

- The name, address and phone number of my physician is _____
- Are you currently under the active care of a physician for a specific condition? Yes No
If so, what is the condition? _____
- Has there been any change in your general health within the past year? Yes No
- Have you had any serious illness within the past five (5) years? Yes No
If so, what was/is the illness? _____
- Have you been hospitalized or had an operation within the past five (5) years? Yes No
If so, what was the reason? _____
- Do you have or have you ever had any of the following diseases or problems:

a. Rheumatic Fever or Rheumatic Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Heart Disease (Artificial Heart Valves, Endocarditis, Congenital heart malformations, Mitral valve prolapse with valvular regurgitation, cardiomyopathy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Cardiovascular Disease (Heart Attack, Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Arteriosclerosis, Stroke, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Hepatitis (any type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Jaundice, Cirrhosis or Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Tuberculosis, Bronchitis or Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Sinus Trouble, Asthma or Hayfever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Severe Headaches, Earaches or Loss of Hearing Hives or Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Fainting Spells, Seizures or Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. Arthritis or Inflammatory Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m. Artificial or Prosthetic Joint Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n. Ulcers, Gastritis, Colitis or other Stomach or Intestinal Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
o. Kidney or Bladder Troubles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
p. Organ Transplant (kidney, heart, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
q. Immune System Disorders (AIDS, HIV, or ARC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
r. Sexually Transmitted Disease (Venereal Disease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
s. Glaucoma, Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
t. Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
- Do you have any blood disorder such as anemia, leukemia or sickle cell anemia? Yes No
- Have you had surgery or radiation treatment for a tumor, growth or other condition? Yes No

10. List any medications (prescription and over-the-counter, such as aspirin or vitamins) that you are now taking or have taken within the past 6 months. Include everything: Antibiotics, Anticoagulants (Blood Thinners), High Blood Pressure Medicine, Cortisone (Steroids), Tranquillizers or Antidepressants, Antihistamines, Insulin or other Diabetic Medications, Digitalis or other Heart Medications, Nitroglycerine, etc.:

11. Are you allergic to or have you ever reacted adversely to any medications? Yes No

If so, list them: _____

- 12. Do you use or have you used street drugs? Yes No
- 13. Do you use tobacco in any form? Yes No
- 14. Do you use any alcohol products? Yes No
- 15. Are you engaged in any situation which exposes you to x-rays or other ionizing radiation? Yes No
- 16. Women - Are you pregnant or do you have any reason to think you may be pregnant? Yes No
- 17. Women - Are you breast feeding (Nursing)? Yes No
- 18. Women - Do you have PMS or problems associated with your menstrual period? Yes No
- 19. Women - Are you taking birth control pills or hormone therapy? Yes No

20. Are you a member of any of the following groups:

- Hemophiliac Dialysis Patient IV Drug User
- Blood Bank Worker History of Hepatitis B Homosexual or Bisexual

21. Do you have any disease, condition or problem not listed above? Yes No

If so, explain _____

22. Have you ever taken Fosamax, Actonel, Boniva, or any drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? Yes No

To the best of my knowledge, I certify that all of the proceeding answers are true, complete and accurate. Additionally, by my signature I hereby authorize Dr. Kim Cassity, D.M.D. and/or such associates or assistants as he may designate to perform those procedures including surgery as my be deemed necessary or advisable to treat my oral condition(s) including arrangement and/or administration of anesthetic, sedative analgesic, therapeutic and/or other pharmaceutical agent(s) including those related to restorative, palliative, surgical, anesthetic sedative, analgesic, medicinal or drug treatment(s) and to voluntarily assume the possible risks with these procedures. I also certify that no guarantee or assurance has been given me that the proposed treatment will be curative and/or successful to my complete satisfaction.

Patient, Parent or Guardian

Date

Dentist

Date

NOTES _____

HEALTH HISTORY UPDATES _____

- Date _____ Change(s) Yes No _____
- Date _____ Change(s) Yes No _____
- Date _____ Change(s) Yes No _____
- Date _____ Change(s) Yes No _____
- Date _____ Change(s) Yes No _____