Health History

Patient's Name_____ Date of Birth _____/_____/_____

Gender: Male/Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe any symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If, yes please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why?_____ Physician's Name: _____
Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?_____ Date of last physical exam ____/____/____

PATIENT MEDICAL HISTORY
Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes No	Glaucoma?	Yes No
Kidney disease or kidney failure, requiring dialysis?	Yes No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes No
Thyroid disease?	Yes No	Liver disease (Jaundice, hepatitis A, B, or C)	Yes No
Stomach ulcers or colitis?	Yes No	Diabetes?	Yes No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes No	Arthritis?	Yes No
Frequent or recurring mouth sores?	Yes No	Significant weight loss or gain?	Yes No
Radiation to the head or neck for cancer treatment ?	Yes No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes No
Any disease, chemotherapy or transplant operation? If so, where?_____ Date of last treatment?_____	Yes No	Sinus or nasal problems? Osteoporosis or osteopenia?	Yes No Yes No

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes please explain:_____

FAMILY MEDICAL HISTORY
Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship_____ Cancer? Yes No Relationship _____

Heart disease? Yes No Relationship_____ Bleeding problems? Yes No Relationship_____

Tumors? Yes No Relationship _____ Lung disease? Yes No Relationship_____

HEALTH HISTORY FORM

Patient's Name_____ Date of Birth _____/_____/_____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS
Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart drugs? Yes No

Steroids (cortisone, prednisone, etc.)? Yes No
antianxiety agents, sedative hypnotics and antidepressants?

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti- diabetic drugs? Yes No

High blood pressure medications? Yes No

Bisphosphonates, antiangeogenic, and/or antiresorptive medications for opteoporosis, multiple myeloma or other caners? If yes, list drugs used and time of use. Yes No

_____

_____

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal, or holistic remedies. vitamins or minerals: _____

ALLERGIES
Are you allergic to or have had an adverse reaction to:

Latex? Yes No

Food products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or Ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problems associated with local anesthesia, general anesthesia and/or intravenous sedation? Yes No If yes, which anesthetic?_____ Relationship? _____

Other drug allergies, not listed above:_____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long?_____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorder? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often?_____

Marijuana? Yes No How often?_____

Recreational drugs? Yes No How often?_____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If yes, please explain?_____
Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, or guardian **Date**

_____
Printed name of patient, parent, guardian/relationship