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?	Yes No	Sinus or nasal problems?	Yes No
If so, where?_____		Osteoporosis or osteopenia?	Yes No
Date of last treatment?_____			
Sleep Apnea	Yes No	Restless Leg Syndrome	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_____

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	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes No
Anticoagulants (blood thinners)?	Yes No	Insulin or oral anti- diabetic drugs?	Yes No
Heart drugs?	Yes No	High blood pressure medications?	Yes No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative hypnotics and antidepressants?	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
GLP-1 Medication	Yes No	Prescription pain medication?	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	Codeine or other pain killers?	Yes No
Food products?	Yes No	Aspirin, Motrin, Aleve, or Ibuprofen?	Yes No
Sedatives, barbiturates?	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:		**Do you use:**		
Drug abuse?	Yes No	Alcohol?	Yes No	How often?_____
Emotional disorder?	Yes No	Marijuana?	Yes No	How often?_____
Alcoholism?	Yes No	Recreational drugs?	Yes No	How often?_____

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