Health History Form

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

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.

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

If yes, please describe: _____

Please list your physician's name and clinic: _____

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

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

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?_____

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	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes (Type I, Type II)?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Gastroesophageal reflux disease (GERD) (Acid reflux)	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Sinus or nasal problems?	Yes	No
			Snoring?	Yes	No
Headaches?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Venereal Disease?	Yes	No
Radiation for cancer treatment?	Yes	No	AIDS/HIV?	Yes	No
Glaucoma?	Yes	No	Sleep Apnea?	Yes	No
Tuberculosis (TB)?	Yes	No			

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? _____, and when was the date of your last treatment? _____

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

If yes, please explain: _____

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
High blood pressure medications?	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers?	Yes	No
Most recent INR number? _____			If yes, list drugs used and time of use.		
Date of most recent INR? _____			_____		
			_____		

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MEDICATIONS Continued

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

_____
_____
_____
_____

Has it ever been recommended by your physician that you take an antibiotic prior to any dental treatment? If yes, please explain:

_____

ALLERGIES

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

Latex?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Codeine or other pain killers?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia? 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 | Alcoholism? Yes No | Anxiety/Depression? Yes No

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, guardian Date

_____

Printed name of patient, parent, guardian/Relationship

_____

Signature of Doctor