Health History Form

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 the 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? _____ 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
			Glaucoma?	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?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer?
Yes No
If so, where? _____, and when was the date of your last treatment?
_____

Health History Form

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

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

Anticoagulants (blood thinners)? Yes No

Heart drugs? Yes No

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

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 osteoporosis, multiple myeloma or other cancers? 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 you 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 problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

Health History Form

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

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 disorders? 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, guardian Date

_____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____