



Health History Form

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

Today's Date: _____ 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? _____					
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

1. Are you pregnant, or is there any chance you might be pregnant? Yes No 2. Are you nursing? Yes No
2. Date of last menstrual period: _____

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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.)? anxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangiogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use.	Yes	No
Prescription pain medication?	Yes	No	_____		

Please list any medications you have taken or are currently taking 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	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

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	Do you use:		
Emotional disorders?	Yes	No	Alcohol?	Yes	No
Alcoholism?	Yes	No	Marijuana?	Yes	No
			Recreational drugs?	Yes	No

How often? _____

How often? _____

How often? _____

PATIENT SURGICAL HISTORY

Have you had any surgical procedures? Yes No

If Yes, please list? _____

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? _____

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