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

Current symptoms: _____

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: _____

_____

Please turn over…

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:

Do you take bisphosphonates, antiangiogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? Yes No

PLEASE LIST ALL MEDICATIONS WITH DOSAGE YOU CURRENTLY TAKE HERE:

including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, 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

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, &/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 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