OFFICE USE ONLY	Date:	Age:	Chart #

Patient:	Ht: ‘ “	Wt: lbs	BP: /	P:

Chief Complaint (Why are you here?):

Answer all questions by checking (Y) Yes or (N) No			Y	N
1		Are you in good health?	☐	☐
2		Any changes in your general health in the past year?	☐	☐
3		Date of last physical exam		
4		Are you now under a doctor’s care for a particular issue?	☐	☐
5		**DO YOU HAVE OR HAVE YOU EVER HAD:**		
	A	Heart (surgery, disease, attack, failure, pacemaker).	☐	☐
	B	High Blood Pressure	☐	☐
	C	Chest Pain	☐	☐
	D	Heart Murmur	☐	☐
	E	Mitral Valve Prolapse.	☐	☐
	F	Rheumatic Fever.	☐	☐
	G	High Cholesterol.	☐	☐
	H	Active Tuberculosis	☐	☐
	I	Prolonged Cough 3-4 weeks or Bloody Cough	☐	☐
	J	Unexplained Weight Loss.	☐	☐
	K	Emphysema or COPD.	☐	☐
	L	Sleep Apnea.	☐	☐
	M	Asthma	☐	☐
		When was your last attack?		
		Have you ever been hospitalized for Asthma?	☐	☐
	N	Stroke or TIA.	☐	☐
	O	Seizures, Convulsions, Epilepsy, Fainting, or Dizziness. . .	☐	☐
	P	Bleeding Disorder, Anemia, Bleeding Tendency,		
		Blood Transfusion? Do you bruise easily?	☐	☐
	Q	Sickle Cell Anemia/Trait.	☐	☐
	R	Liver Disease (Jaundice, Hepatitis).	☐	☐
	S	Kidney Disease Are you on Dialysis?.	☐	☐
	T	Diabetes (Type I or II).	☐	☐
		Do you check your Blood Glucose Daily?.	☐	☐
		What is your Blood Glucose normally?		
	U	Thyroid Disease (Goiter).	☐	☐
	V	Arthritis (Osteo or Rheumatoid).	☐	☐
	W	Acid Reflux, Stomach Ulcers, or Colitis.	☐	☐
	X	Glaucoma.	☐	☐
	Y	Implants placed anywhere in your body.		
		(heart valve, stent,pacemaker, defibrillator, hip, knee). . . .	☐	☐
	Z	Radiation (X-ray) treatment for Cancer	☐	☐
	AA	Any disease, drug, or transplant operation that has		
		depressed your immune system? (Chemotherapy,etc.). . . .	☐	☐
	BB	HIV Positive/AIDS.	☐	☐
	CC	Syphilis, Venereal Disease, or Herpes	☐	☐
	DD	Cold Sores/Fever Blisters.	☐	☐
	EE	Sinus or Nasal Problems.	☐	☐
	FF	Clicking or Popping of jaw joint, pain near ear,		
		difficulty opening mouth, grind or clench teeth.	☐	☐
	GG	Anxiety/ Depresson/ Emotional Disorder?	☐	☐
	HH	Autism, Bipolar Disorder, ADD/ADHD?.	☐	☐

6. Have you **EVER** had any **SERIOUS ILLNESSES**, **SURGERIES**, or **HOSPITALIZATIONS**? If so, list below:

A	Have you had any serious problems associated with dental treatment?		☐	☐
B	Have you or any immediate family member had any problems with intravenous/general anesthesia?.		☐	☐

	Name	Phone
7	Primary Physician:	
	Other:	

8 **Please list ALL medications taken (prescriptions, over-the-counter, herbal or holistic remedies, vitamins or minerals):**

Do you take or have you **ever** taken Bisphosphonates or any of the following medications? (Fosamax, Actonel, Boniva, Aredia, Zometa, Reclast, Didronel, Skelid, Prolia,) . . . . . ☐ ☐

9		**ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**		
	A	Local Anesthesia (Novocaine, Lidocaine,etc.)	☐	☐
	B	Penicillin or other antibiotics	☐	☐
	C	Sedatives, Barbiturates, Benzodiazepines.	☐	☐
	D	Aspirin or Ibuprofen.	☐	☐
	E	Codeine, Hydrocodone, or other pain killers	☐	☐
	F	Latex or Rubber products.	☐	☐
	G	Eggs or Soy.	☐	☐
	H	Other allergies or reactions? Please list below:	☐	☐
10		Do you smoke or chew tobacco?	☐	☐
		Packs per day? How many years?		
11		Do you drink alcohol? How much per day?	☐	☐
12		Do you use any illicit/recreational drugs?.		
13		Is there any past history of Alcohol/Drug Dependency?.	☐	☐
14		**Do you have any other disease, condition, or problem NOT listed above?**	☐	☐
15		Do you wish to talk to the doctor privately about anything?. .	☐	☐

FOR WOMEN ONLY

	A	Are you Pregnant, or even possibly Pregnant?.	☐	☐
		If so, how many weeks?		
	B	Are you nursing (breastfeeding)?.	☐	☐
	C	Depo-Provera Injections	☐	☐
	D	If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives; therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for guidance. _____ (Patient’s Initials)		

Doctor’s Notes: **DO NOT WRITE IN THE SPACE BELOW**

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor. I consent to an oral & maxillofacial examination and necessary x-rays for diagnosis and treatment planning.

Date Signature of Person Completing Health History Doctor’s Initials