HEALTH HISTORY

Patient Name_____ Birth Date_____ Today's Date_____

Primary Physician's Name_____ Physician's Phone Number_____

YES NO

( ) ( ) Are you under a physician's care now (other than routine check-ups)? If yes, please explain:

_____

( ) ( ) Have you ever been hospitalized and/or had a major operation? If yes, please explain:_____

_____

( ) ( ) Have you ever had a serious head or neck injury? If yes, please explain:_____

_____

( ) ( ) Are you taking any medication? If yes, please list them, or if you keep a list with you, we will be happy to make a copy for you._____

_____

( ) ( ) Are you allergic to any medications or substances? If yes, please check below:
( ) Penicillin ( ) Aspirin ( ) Sulfa ( ) Codeine ( ) Latex ( ) Metals
( ) Local anesthetics ( ) Other:_____

( ) ( ) Do you or have you ever smoked or used tobacco products? _____

Do you have or have you ever been treated for any of the following? **Please check those that apply.**

( ) Allergies - seasonal or food
( ) Angina
( ) Arthritis/rheumatism
( ) Artificial joints
( ) Asthma
( ) Bleeding problems
( ) Breathing/respiratory problems
( ) Cancer/chemotherapy
( ) Chemical dependency
( ) Depression
( ) Diabetes
( ) Eating disorders
( ) Epilepsy/seizures
( ) Fainting/dizziness
( ) Fever blisters/cold sores
( ) Fibromyalgia
( ) Frequent/persistent cough
( ) Snoring
( ) GERD (acid reflux)
( ) Glaucoma
( ) Heart attack
( ) Heart disorder (Congenital)
( ) Heart murmur
( ) Heart pacemaker
( ) Heart surgery
( ) Heart valve replacement
( ) Hepatitis/liver problems
( ) High blood pressure
( ) HIV/AIDS
( ) Kidney problems
( ) Mental disorders/psychiatric care
( ) Mitral valve prolapse
( ) Nervous system disorders
( ) Obesity
( ) Retinal Detachment
( ) Osteoporosis
( ) Radiation treatment
( ) Rheumatic fever
( ) Sickle cell disease
( ) Sinus problems
( ) Sjogren's disease
( ) Sleep apnea (CPAP)
( ) Stroke
( ) Surgically placed pins rods, or screws
( ) Thyroid problems
( ) TMJ problems
( ) Tuberculosis
( ) Ulcers
( ) Venereal disease (STD)
( ) Vomiting/nausea

Do you have any health problems that were NOT listed or that need further clarification?

_____

WOMEN (Please check): ( ) Pregnant ( ) Trying to get pregnant ( ) Nursing
( ) Taking oral contraceptives

( ) **YES** ( ) **NO** Do you take or have you ever taken any **Bisphosphonate therapy**? (eg. Fosamax, Boniva, Actonel, Reclast, Aredia, Zometa, Prolia)

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I understand that it is my responsibility to inform the dentist and the staff at my next appointment.

X_____ DATE_____
Signature of patient, parent or guardian

Staff initials_____

FOR OFFICE USE ONLY

Date_____

Health or medication changes: _____

_____

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Staff initials _____

Date_____

Health or medication changes: _____

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Staff initials _____

Date_____

Health or medication changes:_____

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Staff initials_____

Date_____

Health or medication changes_____

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Staff initials _____

Date_____

Health or medication changes: _____

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Staff initials _____

Date_____

Health or medication changes:_____

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Staff initials_____