Health History Form

Patient's Full Name: ______________________ Birth Date: ______________________

Current Health Status: Excellent Good Fair Poor 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 mark your responses and answer ALL questions.

Please describe the reason you are here today for consultation: ______________________

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? ______________________

Have you ever had surgery, been hospitalized, or had a serious illness? Yes No

Please provide details: ______________________

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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
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
Sinus or nasal problems?	Yes	No
Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No
Mental health issue (anxiety, depression)?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No
Osteoporosis or osteopenia?	Yes	No
Any history of cancer, chemotherapy, or tissue/organ transplant? *If so, where?* __________ *and when was your last treatment?* __________	Yes	No
Do you have any other disease, condition, or problem not listed above? *If yes, please explain:* __________ __________ __________ __________	Yes	No
Are you pregnant or is there any chance you might be pregnant?	Yes	No

Family Medical History

Please list any family history of chronic medical condition (e.g. diabetes, asthma, cancer, etc.). Please also indicate the relationship (e.g. Father, Mother).

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Patient's Full Name: ___________________________________

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Medications
Are you using any of the following:

Antibiotics?	Yes	No
Anticoagulants (blood thinners)?	Yes	No
Heart drugs (including blood pressure meds)	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No
Anti-anxiety, sedative-hypnotics, or anti-depressants?	Yes	No
Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Insulin or oral anti-diabetic drugs?	Yes	No
Prescription pain medication?	Yes	No
Bisphosphonates, antiangeogenic, antiresorptive meds for osteoporosis, multiple myeloma or other cancers (e.g. Fosamax, Reclast, Boniva, Prolia, Xgeva, Aredia, Zometa)?	Yes	No

Please list the medications you have taken or are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

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Allergies
Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No
Penicillin or other antibiotics?	Yes	No
Sedatives, barbiturates?	Yes	No
Codeine or other pain killers?	Yes	No
Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No

Others? ____

Anesthesia
Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation?

Yes No *If yes, please explain* ____

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Social History
Have you ever or do you currently use?

Cigarette, chewed tobacco, e-cigarette?	Yes	No	How long/much? ______________________
Alcohol?	Yes	No	How long/much? ______________________
Recreational drugs?	Yes	No	How long/much? ______________________

Dental History

Have you had any adverse effects from dental treatment?	Yes	No	If yes, 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.

Patient/Guardian Signature: ______________________________ Today's Date: ________________

Doctor Signature: ______________________________ Today's Date: ________________