Date _____ # Health History

Patient Name _____ **Date of Birth** _____ **Age** _____

Please complete the Health History so that we may provide the best possible care. The Health History will be reviewed with you prior to beginning treatment. PLEASE BE AS THOROUGH AS POSSIBLE.

GENERAL INFORMATION

Sex: Male / Female (circle) Are you in good health? YES NO Height _____ ft _____ in; Weight_____ lbs.

Has there been any change in your general health in the past year? ……..YES NO

If yes, describe: _____

Physician name and telephone #_____ Date of last physical exam_____

Are you now under a physician's care for a particular problem? ……....YES NO

If yes, describe: _____

DENTAL HISTORY

1. Have you had any serious problems associated with previous dental treatment? ……..... YES NO

If yes, please explain; _____

2. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth? …..... YES NO

If yes, have you had any treatment or therapy? _____

3. Do you grind or clench your teeth? ……..…… YES NO

If yes, have you had any treatment or therapy? _____

4. Have you or immediate family member had any problem associated with anesthesia? ..... …… YES NO

If yes, please explain; _____

PAST MEDICAL HISTORY

1. Cardiovascular disease? …….. YES NO

If yes, please circle (angina, chest pain, heart attack, coronary artery disease, irregular heart rate, palpitations, congenital heart disease, rheumatic heart disease, heart murmur)

2. High blood pressure? …….. YES NO
3. Stroke? …….....YES NO
4. Heart surgery? (bypass or stent) ……..… YES NO
5. Pacemaker? Defibrillator? ….……...…YES NO
6. Respiratory disease? …… YES NO

If yes, please circle (asthma, emphysema, COPD, chronic cough, bronchitis)

7. Epilepsy or seizures? …… YES NO
8. Fainting or dizziness? …… YES NO
9. Bleeding disorder, anemia? …….. YES NO
10. Blood transfusion? ……... YES NO
11. Bruise or bleed easily? …… YES NO
12. Liver disease (jaundice, hepatitis)? ..…… YES NO
13. Kidney disease? ……... YES NO
14. Diabetes (Type?) …… YES NO
15. Thyroid disease? …… YES NO
16. Arthritis? …….. YES NO
17. Stomach ulcers or acid reflux (GERD)? …. YES NO
18. Other GI disease? …….. YES NO
19. Glaucoma? .....…….. YES NO
20. Osteoporosis? …..……. YES NO
21. Implants or joint replacements? ……..... YES NO
22. Radiation therapy? …….. YES NO
23. Chemotherapy? …..…… YES NO
24. Sinus or nasal problems? ……... YES NO
25. Seasonal allergies? ……...….. YES NO
26. Snoring or sleep apnea? ……..…….... YES NO
27. Psychiatric illness? …….. YES NO
28. Disease or medication that has depressed your immune system? ……..…….. YES NO
29. Organ transplant? …..…….. YES NO

Do you have any other disease, condition or problem not listed above that you think the doctor should know? ……YES NO

If yes, please explain; _____

Do you wish to talk to the doctor privately about anything? ..... YES NO

If yes, please explain; _____

PAST SURGICAL HISTORY

Have you ever had any serious illness? If yes, describe: _____

_____

Have you been hospitalized or had surgery during the last 5 years? If yes, describe: _____

MEDICATIONS

Are you currently taking any of the following medications?

1. Antibiotics? ……..……..... YES NO
2. Anticoagulants or blood thinners ……... YES NO
(Coumadin, Plavix, or other)?
3. Aspirin or ibuprofen? ……..… YES NO
4. Steroids (cortisone, prednisone, etc.)?.. YES NO
5. Mood stabilizing or psychiatric drugs? ... YES NO
(tranquilizers, sleep aids, antidepressants)
6. Insulin or oral anti-diabetic drugs?…... YES NO
8. Diet pills? …..……..... YES NO
9. Bisphosphonate bone density medications.. YES NO
(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?
10. Are you currently taking or ever taken any anti-angiogenic or chemotherapy drugs for cancer? YES NO
11. Are you being treated for chronic pain? ……. YES NO
If yes; doctor's name, number _____
12. Have you ever been advised to not take a medication?
If yes, please list below; _____
_____
13. Please list ALL medications you are taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
_____
_____
_____
_____

ALLERGIES OR ADVERSE REACTION

1. Local anesthesia (novocain, etc.)? …. YES NO
2. Penicillin or other antibiotics? ……. YES NO
3. Sedatives, barbiturates? ……. YES NO
4. Aspirin or ibuprofen? ……. YES NO
5. Codeine or other pain medications? ..... YES NO
6. Latex or rubber products? ….……..…. YES NO
7. Chemicals or jewelry (rash or sensitivity)? YES NO
8. Food products? Soy? Eggs? ……. YES NO

9. Other allergies or reactions? If so, please list:
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

1 .Do you smoke or chew tobacco? ..... YES NO
If yes, how much? _____; for how long? _____
2. Is there any past history of alcohol or chemical dependency? …….……..... YES NO
If yes, please explain; _____
3. Is there any past history of chemical dependency or recreational drug use? …….……..... YES NO
If yes, please explain; _____
4. Is there any emotional or psychiatric illness that may affect the care we provide? ……... …….. YES NO
If yes, please explain; _____

FEMALE PATIENTS

1. Please provide the date of you last menstrual period._____
2. Are you pregnant, trying to get pregnant, or is there any chance you might be pregnant? …….. YES NO
If yes, when is your expected delivery date? _____
3. Are you nursing? …… YES NO
4. Are you using Oral Contraceptives? …….. YES NO

PLEASE NOTE: It is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care.
I have read and understand the above information.

DATE; _____ PATIENT'S SIGNATURE; _____

DATE; _____ DOCTOR'S SIGNATURE; _____