HEALTH HISTORY

Patient Name_____Date of Birth_____

Name of Primary Care Physician_____Phone Number_____

Most Recent Physical Exam_____Purpose_____

General Health: __Excellent __Good __Fair __Poor

Do you have or have you ever had:

YES

1. Hospitalization for illness or injury:_____

2. An ALLERGIC reaction to:

__local anesthetics __aspirin
__erythromycin __penicilin
__sulfa drugs __latex
__codeine/other narcotic
__metals
__tetracycline
__other:_____

- 3. Heart problems, or cardiac stent in last 6 months
- 4. History of infective endocarditis
- 5. Artificial heart valve, repaired heart defect (PFO)
- 6. Pacemaker or implantable defribrillator
- 7. Congenital heart defect
- 8. Artificial joint
- 9. High blood pressure
- 10. Low blood pressure
- 11. Stroke
- 12. Anemia or other blood disorder
- 13. Abnormal bleeding
- 14. Hemophilia
- 15. Emphysema / sarcoidosis
- 16. Tuberculosis
- 17. Sleep problems or snore
- 18. Asthma / breathing problems
- 19. Kidney disease
- 20. Thyroid disease or calcium deficiency
- 21. Liver disease

YES

- 22. Hormone deficiency
- 23. Sinus trouble
- 24. Stomach or duodenal ulcer
- 25. Digestive disorders (gastric reflux)
- 26. Osteoporosis/osteopenia
- 27. Head or neck injury
- 28. Epilipsey
- 29. Neurological problems
- 30. Herpes, viral infections or cold sores
- 31. STI/STD
- 32. High cholesterol or taking statin drugs
- 33. Hepatitis (type:_____)
- 34. HIV/AIDS
- 35. Tumor, abdominal growth
- 36. Cancer, chemotherapy, radiation therapy
- 37. Lump or swelling around the mouth
- 38. Mental health disorder
- 39. Diabetes (type I or type II)
- 40. Frequent headaches or migraines

ARE YOU:

- 41. Presently being treated for any other illness
- 42. Aware of a change in your health (fever, cough
- 43. Taking weight management medications
- 44. Often exhausted or fatigued
- 45. FEMALE - are you breastfeeding?
- 46. FEMALE - taking birth control?
- 47. FEMALE - pregnant?
- 48. MALE - prostate disorders?

DO YOU

- 49. Use alcohol (per week_____)
- 50. Use tobacco (smoke, snuff, or chew)

Describe any current medical condition or treatment that may possibly affect your dental treatment (i.e. botox, collagen, injections):_____

_____

List all medications, supplements, and or vitamins taken within the last 2 years

DRUG/DOSAGE	PURPOSE/DATE OF DOSAGE	DRUG/DOSAGE	PURPOSE/DATE OF DOSAGE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS

Patient's Signature:_____Date:_____

Doctor's Signature:_____._____Date:_____