

HEALTH HISTORY FORM

Patient Name _____ Preferred Name _____ Date of Birth _____

Name of Physician _____ Physician's Phone Number (_____) _____

Most Recent Physical Exam _____ Purpose _____

General Health: Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO YES NO

- | | | | | | | | | | | | |
|--|--|----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|--|---------------------------------|--------------------------------|---------------------------------------|---------------------------------------|--|
| <p>1. hospitalization for illness or injury _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. an ALLERGIC reaction to:</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Local anesthetics</td> <td><input type="checkbox"/> Aspirin</td> </tr> <tr> <td><input type="checkbox"/> Penicillin</td> <td><input type="checkbox"/> Erythromycin</td> </tr> <tr> <td><input type="checkbox"/> Sulfa Drugs</td> <td><input type="checkbox"/> Codeine/other narcotics</td> </tr> <tr> <td><input type="checkbox"/> Metals</td> <td><input type="checkbox"/> Latex</td> </tr> <tr> <td><input type="checkbox"/> Tetracycline</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>3. heart problems, or cardiac stent in last 6 months _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. history of infective endocarditis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. artificial heart valve, repaired heart defect (PFO) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. pacemaker or implantable defibrillator _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. congenital heart defect _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. artificial joint (date _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. high blood pressure _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. low blood pressure _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. stroke _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. anemia or other blood disorder _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. abnormal bleeding _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. hemophilia _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. rheumatic or scarlet fever _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>16. emphysema/ sarcoidosis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>17. tuberculosis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>18. sleep problems or snore _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>19. asthma/breathing problems _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>20. kidney disease _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>21. thyroid, parathyroid disease, or calcium deficiency _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>22. liver disease _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>23. jaundice _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>24. hormone deficiency _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>25. sinus trouble _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>26. stomach or duodenal ulcer _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>27. digestive disorders (gastric reflux) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Codeine/other narcotics | <input type="checkbox"/> Metals | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other: _____ | <p>28. osteoporosis/osteopenia (taking bisphosphonates) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>29. arthritis _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>30. glaucoma _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>31. contact lenses _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>32. head or neck injuries _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>33. epilepsy, convulsion, seizures _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>34. neurological problems (if yes, type _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>35. herpes, viral infections or cold sores _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>36. lumps or swelling around the mouth _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>37. High cholesterol or taking statin drugs _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>38. STI/STD _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>39. hepatitis (type _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>40. HIV/AIDS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>41. tumor, abnormal growth _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>42. cancer, chemotherapy, radiation therapy _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>43. mental health disorder(s) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>44. excessive urination _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>45. diabetes (type I or II) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>46. frequent headaches or migraines _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ARE YOU:</p> <p>48. presently being treated for any other illness _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>49. aware of a change in your health (fever, new cough) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>50. taking weight management medications (fen-phen) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>51. taking dietary supplements _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>52. often exhausted or fatigued _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>55. FEMALE - are you breast feeding _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>56. FEMALE - taking birth control _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>57. FEMALE - pregnant _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>58. MALE - prostate disorders _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DO YOU:</p> <p>47. use alcohol (per week _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>54. use tobacco (smoke, snuff, or chew) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Aspirin | | | | | | | | | | |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | | | | | | | | | | |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Codeine/other narcotics | | | | | | | | | | |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Latex | | | | | | | | | | |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other: _____ | | | | | | | | | | |

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 LAST DOSE	DRUG/DOSAGE	PURPOSE/DATE OF LAST DOSE

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

Patient's Signature _____

Date: _____

Doctor's Signature _____

Date: _____