HEALTH HISTORY FORM

Patient Name ________________________________ Preferred 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** **NO**

1. hospitalization for illness or injury ☐ ☐
2. an ALLERGIC reaction to:
   - ☐ Local anesthetics
   - ☐ Aspirin
   - ☐ Penicillin
   - ☐ Erythromycin
   - ☐ Sulfa Drugs
   - ☐ Codeine/other narcotics
   - ☐ Metals
   - ☐ Latex
   - ☐ 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 defibrillator ☐ ☐
7. congenital heart defect ☐ ☐
8. artificial joint (date____________) ☐ ☐
9. high blood pressure ☐ ☐
10. low blood pressure ☐ ☐
11. stroke ☐ ☐
12. anemia or other blood disorder ☐ ☐
13. abnormal bleeding ☐ ☐
14. hemophilia ☐ ☐
15. rheumatic or scarlet fever ☐ ☐
16. emphysema/ sarcoidosis ☐ ☐
17. tuberculosis ☐ ☐
18. sleep problems or snore ☐ ☐
19. asthma/breathing problems ☐ ☐
20. kidney disease ☐ ☐
21. thyroid, parathyroid disease, or calcium deficiency ☐ ☐
22. liver disease ☐ ☐
23. jaundice ☐ ☐
24. hormone deficiency ☐ ☐
25. sinus trouble ☐ ☐
26. stomach or duodenal ulcer ☐ ☐
27. digestive disorders (gastric reflux) ☐ ☐

YES **NO**

28. osteoporosis/osteopenia (taking bisphosphonates) ☐ ☐
29. arthritis ☐ ☐
30. glaucoma ☐ ☐
31. contact lenses ☐ ☐
32. head or neck injuries ☐ ☐
33. epilepsy, convulsion, seizures ☐ ☐
34. neurological problems (if yes, type______________) ☐ ☐
35. herpes, viral infections or cold sores ☐ ☐
36. lumps or swelling around the mouth ☐ ☐
37. High cholesterol or taking statin drugs ☐ ☐
38. STI/STD ☐ ☐
39. hepatitis (type_____) ☐ ☐
40. HIV/AIDS ☐ ☐
41. tumor, abnormal growth ☐ ☐
42. cancer, chemotherapy, radiation therapy ☐ ☐
43. mental health disorder(s) ☐ ☐
44. excessive urination ☐ ☐
45. diabetes (type I or II) ☐ ☐
46. frequent headaches or migraines ☐ ☐

ARE YOU:

48. presently being treated for any other illness ☐ ☐
49. aware of a change in your health (fever, new cough) ☐ ☐
50. taking weight management medications (fen-phen) ☐ ☐
51. taking dietary supplements ☐ ☐
52. often exhausted or fatigued ☐ ☐
55. FEMALE - are you breast feeding ☐ ☐
56. FEMALE - taking birth control ☐ ☐
57. FEMALE - pregnant ☐ ☐
58. MALE - prostate disorders ☐ ☐

DO YOU:

47. use alcohol (per week______________) ☐ ☐
54. 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) : ______________

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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: ____________________