HEALTH HISTORY FORM

Patient Name:____Date:_____________________________________

Birthdate:_____________________Age:__________Sex:________Height:_________Weight:__________Marital Status:__________

Who is your general dentist?____

Who is your family physician?____

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 circle your response.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today:____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why?____

Have you had any of the following?

If so, please circle.

A. Stroke
B. Heart Murmur
C. Rheumatic Fever, Rheumatic Heart Disease
D. Asthma
E. High Blood Pressure
F. Heart Attack
G. Chest Pain
H. Shortness of Breath
I. Emphysema
J. Thyroid Disease
K. Seizures
L. Diabetes
M. Hepatitis, Jaundice, Liver Disease
N. Arthritis
O. Stomach Ulcers
P. Colitis
Q. Kidney Disease
R. Tuberculosis
S. Anemia
T. Neuromuscular Disease
U. Abnormal Bleeding
V. Cancer
W. AIDS/HIV
X. Radiation to head or neck
Y. Osteoporosis or Osteopenia
Z. Frequent or recurrent mouth sores

Family Medical Problems?____

Are you taking any medications? If so, please list:____

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Have you taken bisphosphonates, antiangiogenic and/or antiresponsive medications for osteoporosis, multiple myeloma or other cancers? If yes list drugs used and time of use.____

Do you have a prosthetic joint (i.e. Knee, Hip, etc.)?____

Do you have a prosthetic heart valve?____

Are you allergic to any medications or food products? If so please list____

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Have you or any other member of your family had a bad reaction to any anesthetic? If yes, please explain______________________

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Do you smoke?___________________Chew tobacco?_________________________________Snuff?______________________________

Have you ever sought professional care or been hospitalized for: Drug abuse, Emotional disorders, or Alcoholism? If yes please explain_________________________

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Women: Are you pregnant?______________Any chance of pregnancy?______________Breastfeeding?_______________________

Patient's, Parent, or Guardian's signature____

Doctor's Signature____Date:____