HEALTH HISTORY **Patient:** ________________________________

To our patients: Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have or medications that you may be taking may have an important bearing in the care that you will be receiving. Thank you for assisting us in providing you with the best possible care, by answering the following questions. Your answers will remain confidential.

- Are you in good health? ☐YES ☐NO Height __________ Weight __________ Date of last physical exam _________________
- Have there been any changes in your general health in the last year? ☐YES ☐NO
- Are you under the care of a physician for any condition(s)? ☐YES ☐NO Date of last visit: ________________
  If yes, for what condition(s) are you being treated? ____
  ____
- Have you been hospitalized or had any surgery in the past five years? ☐YES ☐NO Date of hospitalization: ____________________
  Reason for hospitalization ____
- Have you ever taken prescription medication for weight reduction (diet pills)? ☐YES ☐NO
- Are you currently taking, or have you ever taken any of the following medications for the treatment of osteoporosis or cancer?
  ☐ Fosamax (alendronate) ☐ Actonel (risedronate) ☐ Boniva (ibandronate) ☐ Skelid (tiludronate)
  ☐ Didronel (etidronate) ☐ Aredia (pamidronate) ☐ Zometa (zoledronic acid) ☐ **NO**

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:

	Y	N	DOCTOR'S NOTES
rheumatic fever			
damaged heart valve or artificial heart valve			
mitral valve prolapse			
heart murmur			
high blood pressure			
low blood pressure			
chest pain or angina			
heart attack			
irregular heart beat			
cardiac pacemaker			
open heart surgery or angioplasty			
swollen ankles			
bronchitis / pneumonia			
chronic cough			
asthma			
hay fever / sinus problems			
tuberculosis			
emphysema			
shortness of breath			
any other lung trouble			
blood disorders such as anemia			
do you bruise easily?			
prolonged or heavy bleeding			
jaundice, hepatitis, liver disease			
stomach ulcers			
gallbladder trouble			
fainting spells			

	Y	N	DOCTOR'S NOTES
convulsions, seizures, epilepsy			
stroke			
thyroid trouble			
diabetes			
low blood sugar			
kidney trouble			
are you receiving dialysis?			
arthritis, joint trouble			
prosthetic (artificial) joint replacement			
contagious diseases			
sexually transmitted diseases			
AIDS or HIV infection			
have you had radiation or chemotherapy?			
blood transfusion			
cancer, tumor or other growth			
depression or other mental health problems			
removable dental appliances			
eye disease / glaucoma			
do you wear contact lenses?			
pain or clicking of the jaw joints (TMJ)			
malignant hyperthermia			
reaction to anesthesia			
physical impairment or disability			
do you get frequent cold sores?			
do you smoke?			
do you drink alcoholic beverages?			
do you use addictive drugs?			

Patient: ________________________

MEDICATIONS:

Are you currently taking any of the following medications?	Y	N
anticoagulants (blood thinners) including aspirin		
tranquilizers/sleeping pills		
cortisone		
other medications? (*please list*)		

ALLERGIES:

Are you allergic to, or have you ever had a reaction to any of the following?	Y	N
local anesthetics (novocain)		
penicillin or other antibiotics		
sulfa drugs		
barbiturates, sedatives, or sleeping pills		
aspirin		
codeine or other narcotics		
other medications? (*please list*)		

WOMEN: Is there ANY possibility you may be pregnant? ☐YES ☐NO Are you nursing? ☐YES ☐NO Do you take birth control pills? ☐YES ☐NO

IS THERE ANY OTHER CONDITION CONCERNING YOUR HEALTH OF WHICH THE DOCTOR SHOULD BE AWARE? ☐**YES** ☐**NO**

If yes, please explain ____

Primary Care Physician Name: ________________________________ Telephone: ____________________

Other Medical Providers Name: ________________________________ Telephone: ____________________

Name: ________________________________ Telephone: ____________________

Name: ________________________________ Telephone: ____________________

I hereby certify that I have read and understand the above. I acknowledge that my questions, if any, about the above health history questionnaire have been answered to my satisfaction. I will not hold my surgeon or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: ______________________________ Date __________ Reviewed ______________________

UPDATE ______________ CHANGES ____

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Doctor's Notes: ____

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