# Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Gender: Male / Female Height: _____ Weight: _____

***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 responses.***

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

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

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

## PATIENT MEDICAL HISTORY

**Do you have or have you ever had:**

| | | | | | |
|---|---|---|---|---|---|
| Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? | Yes | No | Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? | Yes | No |
| | | | Glaucoma? | Yes | No |
| Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? | Yes | No | Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? | Yes | No |
| Kidney disease or kidney failure, requiring dialysis? | Yes | No | Liver disease (jaundice, hepatitis A, B, or C)? | Yes | No |
| Thyroid disease? | Yes | No | Diabetes? | Yes | No |
| Stomach ulcers or colitis? | Yes | No | Arthritis? | Yes | No |
| Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? | Yes | No | Significant weight loss or gain? | Yes | No |
| | | | Seizures, convulsions, epilepsy, fainting or dizziness? | Yes | No |
| Frequent or recurring mouth sores? | Yes | No | Sinus or nasal problems? | Yes | No |
| Radiation to the head or neck for cancer treatment? | Yes | No | Osteoporosis or osteopenia? | Yes | No |

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

## FAMILY MEDICAL HISTORY

**Do you have a family history of any of the following? If yes, indicate the relationship.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Diabetes? | Yes | No | Relationship _____ | Cancer? | Yes | No | Relationship _____ |
| Heart disease? | Yes | No | Relationship _____ | Bleeding problems? | Yes | No | Relationship _____ |
| Tumors? | Yes | No | Relationship _____ | Lung disease? | Yes | No | Relationship _____ |

# Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

## FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

## MEDICATIONS

**Are you using any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics? | Yes | No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes | No |
| Anticoagulants (blood thinners)? | Yes | No | Insulin or oral anti-diabetic drugs? | Yes | No |
| Heart drugs? | Yes | No | High blood pressure medications? | Yes | No |
| Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants | Yes | No | Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. _____ | Yes | No |
| Prescription pain medication? | Yes | No | _____ | | |

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

## ALLERGIES

**Are you allergic to or have you had an adverse reaction to:**

| | | | | | |
|---|---|---|---|---|---|
| Latex? | Yes | No | Codeine or other pain killers? | Yes | No |
| Food products? | Yes | No | Aspirin, Motrin, Aleve, or ibuprofen? | Yes | No |
| Sedatives, barbiturates? | Yes | No | Penicillin or other antibiotics? | Yes | No |

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

## SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

| **Have you ever sought professional care or been hospitalized for:** | | | **Do you use:** | | | |
|---|---|---|---|---|---|---|
| Drug abuse? | Yes | No | Alcohol? | Yes | No | How often? _____ |
| Emotional disorders? | Yes | No | Marijuana? | Yes | No | How often? _____ |
| Alcoholism? | Yes | No | Recreational drugs? | Yes | No | How often? _____ |

## DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

Do you wish to talk to the doctor privately about anything? Yes No

**I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.**
**To the best of my knowledge, the above information is complete and correct.**

_____ _____
Signature of patient, parent, guardian Date

_____ _____
Printed name of patient, parent, guardian/Relationship Doctor's Signature