Health History Form

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

Gender: _____ Height: _____ Weight: _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

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 doctor'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? _____

Have you ever had **surgery**? Yes No

If yes, when and what for? Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

Have you ever had any **problems with anesthesia (**local anesthesia, general anesthesia, and/or IV sedation)? Yes No

If yes, please describe: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Cardiovascular disease, congenital heart 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
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	Arthritis?	Yes	No
Gastrointestinal problems? Stomach ulcers, colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Cancer, radiation, or chemotherapy?	Yes	No	HIV/AIDS?	Yes	No
Describe: _____			Immunosuppression?	Yes	No

Do you have any other disease, condition or problem **not listed above** 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 _____

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	Prescription pain medication?	Yes	No
Anticoagulants (**blood thinners**)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use: _____ _____	Yes	No

Please list all medications indicated above as well as any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

Pharmacy: _____ Phone: _____ Address: _____

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

Other drug or food allergies not listed above: _____

SOCIAL HISTORY

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

Have you ever sought care or been hospitalized for:

Substance abuse? Yes No

Alcoholism? Yes No

Emotional disorders? Yes No

Do you use:

Alcohol? Yes No How often? _____

Marijuana? Yes No How often? _____

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