



HEALTH HISTORY

Patient's Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Birth Date: _____
 SS#: _____
 Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

General Dentist: _____ Referred By (same []): _____
 Physician: _____ Phone: _____
 In case of an emergency, contact: _____ Phone: _____

Please circle YES or NO below. Your answers are confidential and necessary to treat you properly.

YES NO Are you in good health?

YES NO Have you had any serious illness, operation or been hospitalized in the last five years?

Are you taking any of the following medications? If yes, which one(s):

YES NO Antibiotics? _____

YES NO Blood thinners/ Aspirin therapy? _____

YES NO High Blood Pressure or Heart medications? _____

YES NO Pain medications? _____

YES NO Others? _____

Are you allergic to or had adverse reactions from any of the following? If yes, please describe:

YES NO Local anesthetics? _____

YES NO Latex? _____

YES NO Penicillin or any other Antibiotic? _____

YES NO Codeine or other Narcotics? _____

YES NO Others? _____

YES NO Have you ever had asthma? If yes, when was your last attack?

YES NO Do you currently use or abuse any recreational drug (Cocaine, etc)?

YES NO Do you or have you ever suffered from drug/alcohol addiction?

YES NO Do you have a damaged or prosthetic heart valve, surgically constructed shunt/conduit, mitral valve prolapse, or a heart murmur?

YES NO Have you ever had rheumatic fever, rheumatic heart disease, bacterial endocarditis, cardiomyopathy, or a congenital heart defect?

YES NO Have you ever suffered from angina, a heart attack, or an irregular heart rhythm?

****PLEASE COMPLETE OTHER SIDE****

- YES NO** Do you have a pacemaker?
- YES NO** Have you ever had a TIA or stroke?
- YES NO** Do you have an artificial joint prosthesis? If yes, when was it placed?
- YES NO** Do you have diabetes? If yes, do you take insulin?
- YES NO** Have you ever had hepatitis, jaundice, cirrhosis or liver disease?
- YES NO** Have you ever had a kidney disorder?
- YES NO** Do you ever have arthritis?
- YES NO** Have you ever had stomach ulcers?
- YES NO** Do you have colitis?
- YES NO** Do you have a thyroid disorder?
- YES NO** Have you ever had radiation, chemotherapy or surgery for a cancer/tumor?
- YES NO** Do you have or have you ever had HIV, tuberculosis or any other contagious disease?
- YES NO** Do you have any bleeding problems or blood disorders?
- YES NO** Do you have epilepsy or a seizure disorder?
- YES NO** Do you have a sinus problem?
- YES NO** Have you ever suffered from a TMJ disorder or other jaw joint problems?
- YES NO** Do you have any numbness, tingling, or altered sensation in or around your mouth?
- YES NO** Do you have or have you been treated for bone cancer that originated from other sites (such as breast, lung, prostate, etc)?
- YES NO** Do you have or have you been treated for osteoporosis, osteopenia, Paget's disease, or multiple myeloma?
- YES NO** Are you taking or have you taken any of the following medications: Fosamax (alendronate), Zometa (zoledronate), Aredia (pamidronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), Bonfos/Ostec (clodronate), Didronel (etidronate)?
- YES NO** Are you taking an oral contraceptive?
- YES NO** Are you pregnant?
- YES NO** Are you nursing?

If you have any condition or problem not listed above that you think I should know about, please describe it here:

Patient Signature

Date

Doctor Signature

Date