HEALTH HISTORY

Patient First Name | MI | Last Name | Birthdate | Sex ☐ Male ☐ Female

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations or hospitalizations? ☐ Yes ☐ No
2. Are you under a physician's care at this time? ☐ Yes ☐ No

Name, address and phone # of physician:

Do you have or did you ever have any of the following?

Cardiovascular Health

3. High blood pressure ☐ Yes ☐ No
4. Angina or heart attack ☐ Yes ☐ No
5. Chest pain on physical exertion ☐ Yes ☐ No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐ Yes ☐ No
7. Heart valve problem or replacement ☐ Yes ☐ No
8. Heart murmur ☐ Yes ☐ No
9. Heart disease, problem or treatment ☐ Yes ☐ No
10. Rheumatic fever ☐ Yes ☐ No
11. Past use of Fen-Phen ☐ Yes ☐ No
12. Irregular heart beat or pacemaker ☐ Yes ☐ No
13. Difficulty breathing when lying down ☐ Yes ☐ No
14. Stroke ☐ Yes ☐ No
15. Low blood pressure ☐ Yes ☐ No

Respiratory Health

16. Asthma ☐ Yes ☐ No
17. Emphysema or respiratory problems ☐ Yes ☐ No
18. Chronic sinus problems ☐ Yes ☐ No
19. Tuberculosis or persistent cough ☐ Yes ☐ No

Endocrine/Blood/Immune Health

20. Diabetes ☐ Yes ☐ No
21. Frequent thirst or frequent urination ☐ Yes ☐ No
22. Thyroid problems ☐ Yes ☐ No
23. Abnormal bleeding, bruise easily ☐ Yes ☐ No
24. Hemophilia ☐ Yes ☐ No
25. Anemia/blood disease ☐ Yes ☐ No
26. Cancer ☐ Yes ☐ No
27. Radiation therapy/chemotherapy ☐ Yes ☐ No
28. HIV infection/AIDS ☐ Yes ☐ No
29. Cold sores/canker sores ☐ Yes ☐ No
30. Organ transplant ☐ Yes ☐ No
31. Blood transfusion ☐ Yes ☐ No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐ Yes ☐ No
33. Arthritis ☐ Yes ☐ No
34. Osteoporosis ☐ Yes ☐ No
35. Fainting spells or dizziness ☐ Yes ☐ No
36. Seizures ☐ Yes ☐ No
37. Numbness or muscle weakness ☐ Yes ☐ No
38. Multiple sclerosis ☐ Yes ☐ No
39. Mental retardation ☐ Yes ☐ No
40. Dementia/Alzheimer's disease ☐ Yes ☐ No
41. Anxiety/Nervousness ☐ Yes ☐ No
42. Mental health treatment ☐ Yes ☐ No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A, B, C or other) ☐ Yes ☐ No
44. Liver disease ☐ Yes ☐ No
45. Kidney disease/dialysis ☐ Yes ☐ No
46. Stomach trouble/ulcers ☐ Yes ☐ No
47. Sexually transmitted disease ☐ Yes ☐ No

Medication Allergies and Other Allergies

48. Penicillin or other antibiotics ☐ Yes ☐ No
49. Sulfa drugs ☐ Yes ☐ No
50. Dental antesthetic ☐ Yes ☐ No
51. Aspirin ☐ Yes ☐ No
52. Codeine/narcotics ☐ Yes ☐ No
53. Iodine ☐ Yes ☐ No
54. Latex products ☐ Yes ☐ No
55. Metals/nickels/jewelry ☐ Yes ☐ No
56. Other: ☐ Yes ☐ No

Females Only

57. Are you pregnant? ☐ Yes ☐ No
58. Are you nursing now? ☐ Yes ☐ No
59. Do you take birth control pills? ☐ Yes ☐ No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐ Yes ☐ No

If so, please list them and the dose taken:

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

Social

62. Do you use tobacco? ☐ Yes ☐ No Quantity _____ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity _____ ☐ Per Day ☐ Per Week
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity _____ Per Day
65. Do you have any other medical conditions not already listed above? ☐ Yes ☐ No

Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ ID# _____ Date _____

UPDATE Have there been any changes in your medical history, including any medications that you take, since you last completed this form? ☐ Yes ☐ No

Signature of PATIENT or GUARDIAN Date

Signature of DENTIST Date