

PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH _____

1. PLEASE CHECK (✓) YES OR NO TO ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease or Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N GERD (esophageal reflux) | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcer/Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina (Chest Pain) | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease/Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Defibrillator | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Use | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Addiction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Convulsions | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Trouble | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting or Dizzy Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus/Nasal Problems |

**CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. (IF IN DOUBT, CIRCLE YES.)
(IF YES, PLEASE GIVE DETAILS.) CONTINUE COMMENTS ON BACK IF NECESSARY.**

2. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR? PLEASE EXPLAIN:	YES	NO
3. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS, INCLUDING DIET PILLS, NON-PRESCRIPTION OR NATURAL REMEDIES? PLEASE LIST:	YES	NO
4. ARE YOU ALLERGIC TO ANY MEDICINE, FOOD, OR MATERIALS, INCLUDING PENICILLIN, CODEINE, NARCOTICS OR LATEX? PLEASE LIST:	YES	NO
5. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? PLEASE EXPLAIN:	YES	NO
6. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT? PLEASE EXPLAIN:	YES	NO
7. HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION WITHIN THE PAST 5 YEARS?	YES	NO
8. HAVE YOU HAD AN ARTIFICIAL JOINT REPLACEMENT (KNEE, HIP, SHOULDER, ETC.)?	YES	NO
9. HAVE YOU EVER HAD RADIATION THERAPY TO THE HEAD, NECK OR JAWS?	YES	NO
10. ARE YOU TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATE DRUGS FOR OSTEOPOROSIS OR TREATMENT FOR MULTIPLE MYELOMA OR OTHER CANCERS (FOSAMAX, ACTONEL, BONIVA, RECLAST, AREDIA OR ZOMETA)?	YES	NO
12. DO YOU HAVE PROLONGED BLEEDING FOLLOWING A CUT, INJURY OR MEDICAL/DENTAL PROCEDURE?	YES	NO
13. DO YOU HAVE ANY REASON TO BELIEVE YOUR IMMUNE SYSTEM MAY BE SUPPRESSED/YOU ARE PRONE TO INFECTIONS?	YES	NO
14. DO YOU HAVE ANY HISTORY OF TMJ PROBLEMS OR CLICKING/POPPING OF JAW JOINT, PAIN NEAR YOUR EAR, DIFFICULTY OPENING YOUR MOUTH, GRINDING OR CLENCHING YOUR TEETH?	YES	NO
15. DO YOU WISH TO TALK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING?	YES	NO
16. WOMEN: ARE YOU PREGNANT? <small>(If YES, please circle trimester block)</small>	YES	NO
TRIMESTER 1 2 3	ARE YOU BREAST FEEDING?	
	YES	NO

I understand the importance of giving a complete and accurate health history, and I certify that I have completed this form to the best of my knowledge.

Signature of Patient, Parent or Guardian _____ Date _____ Doctor's Initials _____ Date _____