Health History

Patient Name: _____ Birthdate: _____ Chart: _____

Please mark any past or current conditions:

Blood/Bleeding Disorder ... _____	YES	NO	Congestive Heart Failure	YES	NO
Chest Pain/Angina	YES	NO	Congenital Heart Defect.. type? _____	YES	NO
Heart Attack... If yes, when? _____	YES	NO	Heart Valve Replacement.. when? _____	YES	NO
Stroke... If yes, when? _____	YES	NO	Rheumatic Fever/Heart Disease.. when? _____	YES	NO
High Cholesterol	YES	NO	Pacemaker	YES	NO
High Blood Pressure	YES	NO	Stents...if yes, placed when? _____	YES	NO
Heart Infection... if yes, when? _____	YES	NO	Other Heart Diseases: _____	YES	NO
Asthma... If yes, how often? _____	YES	NO	Emphysema	YES	NO
Hay Fever/Seasonal Allergies	YES	NO	COPD	YES	NO
Tuberculosis	YES	NO	Other Lung Problems: _____	YES	NO
Organ Transplant: _____	YES	NO	Stomach/Intestinal Disease/Ulcers	YES	NO
Liver Problems : _____	YES	NO	Acid Reflux	YES	NO
Hepatitis B or C : _____	YES	NO	Epilepsy/Seizures.. how often? _____	YES	NO
Thyroid Disease: type? _____	YES	NO	Osteoporosis	YES	NO
Jaw Joint Pain	YES	NO	Frequent Mouth Sores/Lesions	YES	NO
Arthritis	YES	NO	HIV or AIDS	YES	NO

Mental/Psychological Disorder	YES	NO	
Circle all that apply: Anxiety Depression Dementia Alzheimer's Bipolar ADHD Other: _____			
Have you ever taken Bisphosphonates?	YES	NO	
Such as Fosamax, Actonel, Boniva? ORAL ___ IV___ WHEN_____ FOR HOW LONG_____			
Diabetes	YES	NO	
If yes, which type? _____ What was your last 3 month blood test percentage (A1c)? _____			
Joint Replacement	YES	NO	
If yes, which joint? _____ Date of Replacement? _____ Do you need premed antibiotics? _____			
Cancer – current or previous	YES	NO	
If yes, which type? _____ When? _____ Treatment: Surgery Chemotherapy Radiation			
Alcohol Use	YES	NO	How often and how much?
Cigarette or Vape Use	YES	NO	Which one and how often?
Street Drug Use	YES	NO	Type of drug and how often?
Are you currently receiving treatment of an ongoing medical condition?	YES	NO	If yes, for what condition? _____
Have you been hospitalized or had a serious illness ***within the last two years***?	YES	NO	If yes, please explain: _____
Have you ever had a problem with dental anesthetics or dental materials?	YES	NO	If yes, please explain: _____
Do you have any other medical problems that were not already mentioned?	YES	NO	If yes, please explain: _____
Who is your physician? _____			When was your last visit to a physician? _____

Please list any known allergies:

Please list ALL of the medications that you are taking:

Women Only

Are you currently pregnant? YES NO Are you currently nursing? YES NO

If yes, list due date:_____

Do you snore at night: YES NO If yes, are you interested in a snoring appliance: YES NO

Today's BP: _____/_____

Received COVID-19 vaccine: YES NO

Tested positive for COVID within 14 days: YES NO

Please Complete:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Your Name: _____

Signature: _____

Dentist Signature: _____

(for office use only)
Assistant initials:

"PAPER" CODE: ☐