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	YES	NO
Heart Attack... If yes, when? _____	YES	NO	Heart Valve Replacement	YES	NO
Stroke... If yes, when? _____	YES	NO	Rheumatic Fever, Rheumatic Heart Disease	YES	NO
High Cholesterol	YES	NO	Pacemaker	YES	NO
High Blood Pressure	YES	NO	Stents	YES	NO
Heart Infection	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	YES	NO
Thyroid Disease	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: _____			
Do you take or have you taken bisphosphonates (such as Fosamax, Actonel, Boniva)?	YES	NO	
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? _____			
Cancer – current or previous	YES	NO	
If yes, which type? _____ Treatment (circle all that apply): Surgery Chemotherapy Radiation			
Alcohol Use	YES	NO	How often and how much?
Cigarette Use	YES	NO	How often and how much?
Street Drug Use	YES	NO	How often and how much?
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:_____

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: _____

(for office use only)
Assistant initials: