Health History Form

NAME: DOB

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond/review each question honestly and completely.

/10 pain? Gender: Height: Weight: Age:

Describe your current health: ◉ Excellent ○ Fair ○ Poor Date of last physical Exam

Describe (dental) symptoms/problems: Are you in or have had pain? ○ Y ◉ N If Yes, Where? How long?

Any changes to your health in the past year? ○ Y ◉ N If Yes, why? Are you now under a doctor's care for a particular problem at this time? ○ Y ◉ N

Have you ever had surgery? ○ Y ◉ N If YES, please provide date and reason for surgery

NONE

PATIENT MEDICAL HISTORY. Do you have or have you ever had

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	○ Y	◉ N	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	○ Y	◉ N
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	○ Y	◉ N	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	○ Y	◉ N
Kidney disease or kidney failure, requiring dialysis?	○ Y	◉ N	Liver disease (jaundice, hepatitis A, B, or C)?	○ Y	◉ N
Thyroid disease?	○ Y	◉ N	Arthritis?	○ Y	◉ N
Stomach ulcers or colitis?	○ Y	◉ N	Significant weight loss or gain?	○ Y	◉ N
Click, pop, pain in jaw joint and/or difficulty opening mouth?	○ Y	◉ N	Seizures, convulsions, epilepsy, fainting or dizziness?	○ Y	◉ N
Frequent or recurring mouth sores?	○ Y	◉ N	Sinus or nasal problems?	○ Y	◉ N
Glaucoma?	○ Y	◉ N	Sleep apnea?	○ Y	◉ N
Diabetes?	○ Y	◉ N	Osteoporosis or osteopenia?	○ Y	◉ N

Do you have any other disease, condition, or problem not listed above, that doctor should know about? ○ Y ◉ N If YES, please explain:

None

FEMALE: Are you or any chance you may be pregnant? ○ Y ◉ N

FAMILY MEDICAL HISTORY. Do you have a family history of any of the following? If yes, relationship?

Diabetes ○ Y ◉ N	Cancers ○ Y ◉ N	Bleeding ○ Y ◉ N	
Heart Disease ○ Y ◉ N	Tumor ○ Y ◉ N	Lung Disease ○ Y ◉ N	Sleep Apnea ○ Y ◉ N

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MEDICATIONS. Are you using any of the following?

Antibiotics?	○Y ⊙N	Prescription pain medication?	○Y ⊙N
Anticoagulants (blood thinners)?	○Y ⊙N	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	○Y ⊙N
Heart medications?	○Y ⊙N	Insulin or oral anti-diabetic drugs?	○Y ⊙N
Steroids (cortisone, prednisone, etc.)?	○Y ⊙N	Blood pressure medications?	○Y ⊙N
Antianxiety agents, antidepressants or other psychiatric medications?	○Y ⊙N	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use.	○Y ⊙N

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals (please include NAME and DOSAGE):

NONE

ALLERGIES. Are you allergic or have had an adverse reaction to (if YES, please describe your reaction):

		Reaction			Reaction
Latex	○Y ⊙N		Codeine or other pain killers	○Y ⊙N	
Food Products	○Y ⊙N		Aspirin, Motrin, Aleve, or Ibuprofen	○Y ⊙N	
Sedatives Barbiturates	○Y ⊙N		Penicillin or other antibiotics	○Y ⊙N	

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? ○Y ⊙N

If Yes, which anesthetic? Relationship? NONE

Other food allergies not listed above? NONE

SOCIAL HISTORY. Have you ever sought professional care,been hospitalized, or used any of the following:

Substance Abuse ○Y ⊙N Alcohol ○Y ⊙N Marijuana ○Y ⊙N Tobacco ○Y ⊙N Years

Emotional Disorder ○Y ⊙N Alcoholism ○Y ⊙N Recreational Drugs ○Y ⊙N # Packs/day

DENTAL HISTORY. Any adverse effects from dental treatment? ○Y ⊙N Do you wish to talk to doctor privately about anything? ○Y ⊙N If YES, please explain:

NONE

ACKNOWLEDGEMENT. I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct. I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form

PRIVACY NOTICE. I authorize doctor and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of examination and treatment to other doctors, providers, and/or insurance carriers. I permit messages to be left on voice mail, mobile phone, or any other electronic devices. I hereby acknowledge that a copy of this office's notice of Privacy Practices has been made available to me and subject to change at any time. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient, Parent, and/or Guardian Date

Print Name

HEALTH HISTORY UPDATE. I have reviewed and noted any changes if any

Date Comments Signature

Print