Health History Form

Patient's Name _____ Date of Birth ____/____/____

Preferred Pharmacy _____ Height: _____ Weight: _____

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

Allergies: List all medication, food and/or latex: _____

Medications: Please list or provide a copy of any medications you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

Have you ever taken Bisphosphonates medications for osteoporosis, multiple myeloma or other cancers? Yes No

If yes, which medication? _____

Do you have or have you ever had: (please circle)

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, Physician's name? _____

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No

Do you wish to talk to the doctor privately about anything? Yes No

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, how much/long? _____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No Emotional disorders? Yes No Alcoholism? Yes No

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.

_____ _____

Signature of patient, parent, guardian Date

_____

Printed name of patient, parent, guardian/Relationship