HEALTH HISTORY

For your safety, please complete this form accurately and completely. **This information is confidential**.

UPDATED 01/20

A) GENERAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: □M □F

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ SSN#: (*needed for ins. claims*) _____

Mobile #: _____ Home #: _____ Work #: _____

Height: _____ Weight: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you currently have a primary care provider? (*doctor, phys. asst, nurse practitioner)*……. □ Yes □ No

Name: _____ Date of last visit: _____

Office Location: _____ Office Phone: _____

Have there been any changes in your general health within the past year?.....□ Yes □ No

Have you had a hospital stay, serious illness, or operation in the past 5 years?..... □ Yes □ No

If yes to any, please describe: _____

B) MEDICATIONS / SUPPLEMENTS □ None

List below, on back, or attach list.

Drug:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C) ALLERGIES/SENSITIVITIES □ None

□ Penicillin □ Sulfa
□ Latex □ Ibuprofen
□ Metals □ Other antibiotics
□ Other: _____
_____

D) PREMEDICATION FOR DENTAL VISITS *Have you had or do you have any of the following?:*

1. Total joint replacement (knee, hip, etc)..□ Yes □ No
2. Artificial (prosthetic) heart valve……□ Yes □ No
3. Infective endocarditis……□ Yes □ No
4. Heart transplant……□ Yes □ No
5. Congenital heart disease (CHD)……□ Yes □ No
6. Other condition requiring premedication:_____

E) BISPHOSPHONATES *Have you taken, do you take, or will you be taking any of the following?:*

1. Oral bisphosphonates such as alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or other bone-related conditions?..... □ Yes □ No
2. Intravenous (IV) bisphosphonates such as Aredia® or Zometa® for cancer or other conditions?..... □ Yes □ No

F) FOR WOMEN ONLY

1. Are you pregnant, or do you think you might be pregnant?..... □ Yes □ No
2. Are you nursing/breastfeeding?..... □ Yes □ No
3. Are you taking birth control pills or hormone replacement?..... □ Yes □ No

HEALTH HISTORY, continued

G) MEDICAL INFORMATION *Do you currently have, or have a history of any of the following?:*

	Y	N		Y	N		Y	N
1. Cardiovascular disease	□	□	19. Autoimmune disease	□	□	37. Hepatitis	□	□
2. Chest pain/angina	□	□	20. Lupus	□	□	38. Other liver problem	□	□
3. Arteriosclerosis	□	□	21. Asthma	□	□	39. Epilepsy or seizures	□	□
4. Congestive heart failure	□	□	22. Bronchitis	□	□	40. Fainting	□	□
5. Damaged heart valves	□	□	23. Emphysema	□	□	41. Other neurologic problem	□	□
6. Heart attack	□	□	24. Sinus trouble	□	□	42. Sleep disorder	□	□
7. Heart murmur	□	□	25. Tuberculosis	□	□	43. Sleep apnea	□	□
8. Low blood pressure	□	□	26. Other respiratory problem	□	□	44. Mental health disorder	□	□
9. High blood pressure	□	□	27. Cancer/Chemo/Radiation	□	□	45. Depression	□	□
10. Pacemaker	□	□	28. Chronic pain	□	□	46. Drug/alcohol addiction	□	□
11. Other heart condition	□	□	29. Diabetes	□	□	47. Recurrent infections	□	□
12. Abnormal bleeding	□	□	30. Eating disorder	□	□	48. Kidney problem	□	□
13. Anemia	□	□	31. Gastrointestinal disease	□	□	49. Osteoporosis	□	□
14. Blood transfusion	□	□	32. GERD/acid reflux	□	□	50. Headaches/migraines	□	□
15. Hemophilia	□	□	33. Stomach ulcers	□	□	51. Venereal diseases (STDs)	□	□
16. AIDS or HIV	□	□	34. Thyroid problems	□	□	52. Visual impairment	□	□
17. Arthritis	□	□	35. Stroke	□	□	53. Hearing impairment	□	□
18. Rheumatoid arthritis	□	□	36. Glaucoma	□	□	54. Limited mobility	□	□

H) DENTAL INFORMATION

	Y	N		Y	N
1. Do your gums bleed easily?	□	□	10. Do you have head or neck pain?	□	□
2. Are your teeth sensitive to hot or cold?	□	□	11. Do you have jaw pain?	□	□
3. Are you teeth sensitive to sweets?	□	□	12. Do you believe you clench or grind your teeth?	□	□
4. Does food catch between your teeth?	□	□	13. Do you wear dentures or partials?	□	□
5. Is your mouth too dry?	□	□	14. Have you ever had a serious mouth injury?	□	□
6. Have you had any gum treatments in the past?	□	□	15. Do you have anxiety about dental treatment?	□	□
7. Have you ever had orthodontics (braces)?	□	□	16. Have you had any bad dental experiences?	□	□
8. Do you have fluoride in your water?	□	□	17. Have you had problems with past dental work?	□	□
9. Do you have tooth pain?	□	□	18. Are you happy with how your teeth look?	□	□

H) DRUG AND ALCOHOL USE

1. Do you use tobacco? □ Yes □ No What type? About how much per week? _____
2. Do you drink alcohol? □ Yes □ No About how many drinks per week? _____
3. Have you recently used any other recreational drugs? □ Yes □ No

Do you have any other disease, condition, or problem not listed? _____

_____

Signature (*parent/guardian if under 18yo*): _____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____