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

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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)? | Yes | No | Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?Glaucoma?  | YesYes | NoNo |
| 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?Seizures, convulsions, epilepsy, fainting or dizziness? | YesYes | NoNo |
| 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 NoIf 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FAMILY MEDICAL HISTORY****Do you have a family history of any of the following? If yes, indicate the relationship.** |
| Diabetes? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cancer? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart disease? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Bleeding problems? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tumors? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Lung disease? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_ |
| **FEMALE PATIENTS** Are you pregnant, or is there any chance you might be pregnant? Yes No |

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| **MEDICATIONS****Are you using any of the following:**  |  |  |  |  |  |
| Antibiotics? | Yes | No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes | No |
| Anticoagulants (blood thinners)? | Yes | No | Insulin or oral anti-diabetic drugs? | Yes | No |
| Heart drugs? | Yes | No | High blood pressure medications? | Yes | No |
| Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressantsPrescription pain medication? | YesYes | NoNo | Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
| Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ALLERGIES****Are you allergic to or have you had an adverse reaction to:** |
| Latex? Yes No  | Codeine or other pain killers? Yes No  |
| Food products? Yes No  | Aspirin, Motrin, Aleve, or ibuprofen? Yes No  |
| Sedatives, barbiturates? Yes No  | Penicillin or other antibiotics? Yes No  |

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other drug allergies not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SOCIAL HISTORY** |
| Have you ever smoked or chewed tobacco? Yes No  |  If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Have you ever sought professional care or been hospitalized for:**  | **Do you use:** |
| Drug abuse? Yes No  | Alcohol? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Emotional disorders? Yes No Alcoholism? Yes No  | Marijuana? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ Recreational drugs? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DENTAL HISTORY** |
| Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you wish to talk to the doctor privately about anything? 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.

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Signature of patient, parent, guardian Date

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Printed name of patient, parent, guardian/Relationship Doctor’s Signature

**HEALTH HISTORY UPDATE**

Date Comments Doctor’s Signature

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