# Health History Form

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

Gender: _____ Height: _____ Weight: _____

***Address:***_____ ***Home #:***_____

***SSN***_____ ***E-mail:*** _____ ***Mobile #:***_____

***Preferred communication method: ___ Home Phone ___ Mobile Phone ___ E-mail***

***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 doctor'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?_____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery:_____ Reason for surgery:_____

Date of surgery:_____ Reason for surgery:_____

## 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)? | 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 | Arthritis? | Yes | No |
| Stomach ulcers or colitis? | Yes | No | Significant weight loss or gain? | Yes | No |
| Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? | Yes | No | Seizures, convulsions, epilepsy, fainting or dizziness? | Yes | No |
| Frequent or recurring mouth sores? | Yes | No | Sinus or nasal problems? | Yes | No |
| Glaucoma? | Yes | No | Sleep apnea? | Yes | No |
| Diabetes? | Yes | No | Osteoporosis or osteopenia? | Yes | No |

Any cancer, radiation, or chemotherapy? Yes No

Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> 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 _____ |
| Sleep Apnea? | Yes | No | Relationship _____ | | | | |

## FEMALE PATIENTS

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

## MEDICATIONS

**Are you using any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics? | Yes | No | Prescription pain medication? | Yes | No |
| Anticoagulants (blood thinners)? | Yes | No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes | No |
| Heart medications? | Yes | No | Insulin or oral anti-diabetic drugs? | Yes | No |
| Steroids (cortisone, prednisone, etc.)? | Yes | No | Blood pressure medications? | Yes | No |
| Antianxiety agents, antidepressants or other psychiatric medications? | Yes | No | Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____ | Yes | No |

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:

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## 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 or food allergies not listed above: _____

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## SOCIAL HISTORY

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

**Have you ever sought professional care or been hospitalized for:**

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

**Do you use:**

Alcohol? Yes No How often? _____
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.**

_____ _____
Signature of patient, parent, guardian Date

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

## HEALTH HISTORY UPDATE

| Date | Comments | Doctor's Signature |
|---|---|---|
| | | |
| | | |