HEALTH HISTORY

Today's Date: _______________
Patient's Name: ______________________________ Nickname: _______________ □ M □ F Birthdate: ____________
Guardian (if under 18): ___________________________ Relation: ________________
Address: __________________________ City: ______________ State: ___ Zip: _______ Spouse: __________________
Home Phone: _____________ Work Phone: ____________ Cell Phone: _____________ Email: ___________________
May we call you at work? ( )Y ( )N Best number to call you:___________ How were you referred to us: _____________
Occupation: ________________________ Employer: ______________________ Previous dentist: _________________

Place a mark on "Y" or "N" to indicate if you have or had any of the following:

Heart Disease or Heart Defect	( ) Y	( ) N	Epilepsy	( ) Y	( ) N	Often exhausted/fatigued	( ) Y	( ) N
Infective Endocarditis	( ) Y	( ) N	Kidney problems/Transplant	( ) Y	( ) N	Viral: Hepatitis HPV Herpes	( ) Y	( ) N
Prosthetic Heart Valve	( ) Y	( ) N	Dialysis	( ) Y	( ) N	HIV / AIDS	( ) Y	( ) N
Stroke	( ) Y	( ) N	Respiratory Problem	( ) Y	( ) N	Radiation Treatment	( ) Y	( ) N
IV Devices or Pacemaker	( ) Y	( ) N	Sleep Apnea or Device	( ) Y	( ) N	Chemotherapy	( ) Y	( ) N
High Blood Pressue	( ) Y	( ) N	Tuberculosis	( ) Y	( ) N	Asthma	( ) Y	( ) N
Low Blood Pressure	( ) Y	( ) N	Emphysema	( ) Y	( ) N	Sinus Trouble	( ) Y	( ) N
Blood Disorder	( ) Y	( ) N	Persistent cough >3 weeks	( ) Y	( ) N	Glaucoma	( ) Y	( ) N
Anemia	( ) Y	( ) N	Cough with blood	( ) Y	( ) N	Frequent Headaches	( ) Y	( ) N
Bleeding Problems	( ) Y	( ) N	Unplanned weight loss	( ) Y	( ) N	Hives, skin rash	( ) Y	( ) N
Diabetes	( ) Y	( ) N	Jaundice	( ) Y	( ) N	Dry Mouth	( ) Y	( ) N
Thyroid Problems	( ) Y	( ) N	Liver Disease	( ) Y	( ) N	Mitral Vale Prolapse	( ) Y	( ) N

Stents or Shunts?	( ) Y	( ) N	Date:_____________________
Hip Replacement?	( ) Y	( ) N	Date:_____________________
Knee Replacement?	( ) Y	( ) N	Date:_____________________
Implants?	( ) Y	( ) N	Type: _____________________
Cancer?	( ) Y	( ) N	Type: _____________________
Arthritis?	( ) Y	( ) N	Type: _____________________

WOMEN: *Are you...* □ Pregnant/Trying to get pregnant □ Nursing □ Taking oral contraceptives

Are you currently being treated for any condition? ( )Y ( )N ____

Alcohol and tobacco use can contribute to a risk of **oral cancer** and **dry mouth**, therefore we ask the following:
Alcohol use: ( ) None ( ) Occasional ( ) Regularly more than 3 drinks per day (higher risk)
Do you Smoke? ( )Y ( )N Chew/Dip tobacco? ( )Y ( )N

Are you taking any medications regularly (Including Aspirin, Herbs, Vitamins, Supplements)? ( )Y ( )N Please list below

Medications: Name/Dose	Reason	Name/Dose	Reason
_______________________	________________	_______________________	________________
_______________________	________________	_______________________	________________
_______________________	________________	_______________________	________________
_______________________	________________	_______________________	________________

Do you require pre-medication prior to surgery or dental treatment? ( )Y ( )N Reason: ___________________________

Have you ever taken:
□ Fosamax □ Boniva □ Prolia □ Actonel □ Aredia □ Zometa □ Phen-Phen □ Eliquis □ Apixaban □ Fish Oil

Allergies: □ None

□ Penicillin	□ Amoxicillin	□ Clindamycin	□ Sulfa	□ Tetracycline
□ Aspirin	□ Tylenol	□ Ibuprofen	□ Codeine	□ Hydrocodone (Vicodin)
□ Latex	□ Novacaine	□ Benedryl	□ Other ________________________________	

Consent

Physician's Name: ______________________ Phone: _____________ Preferred Pharmacy: ____________________

In case of a medical emergency, who may we contact?
Name: ______________________________ Relation: _____________________ Phone: __________________
Name: ______________________________ Relation: _____________________ Phone: __________________

I certify that the above information is correct to the best of my knowledge: ________________________________
Patient/Guardian Signature

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