HEALTH HISTORY

Today's Date: ____________________

Patient Name: ____ Birth Date: ________________

-PLEASE ANSWER EACH QUESTION-

YES NO

☐ ☐ Are you under the care of a Medical Physician?

☐ ☐ Have you ever been hospitalized for any surgical operation/serious illness? Please describe:

____

____

☐ ☐ Are you taking any medications/nonprescription medications, herbal medicines/vitamins? Please list:

____

____

____

☐ ☐ Do you use tobacco?

YES NO

☐ ☐ Does your Medical Physician currently require you to take antibiotics (pre-medication) before dental visits for a heart murmur, prosthetic joint, or cancer?

☐ ☐ Are you taking any phosphodiesterase inhibitor (erectile/sexual dysfunction) medication? (Ex. Viagra, Cialis, etc.)

☐ ☐ Have you ever taken bisphosphonate medication for your bones or cancer? (Ex. Fosamax, Boniva, etc.)

Are you allergic to or ever had any reaction to:

☐ ☐ Local Anesthetics

☐ ☐ Antibiotics: ________________________

☐ ☐ Other: ________________________

-DO YOU NOW HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?-

YES NO

-Respiratory / Lungs-

☐ ☐ Pneumonia / Flu

☐ ☐ Asthma / Bronchitis

☐ ☐ Emphysema

☐ ☐ Shortness of Breath / Easily Winded

☐ ☐ Tuberculosis
Date: ____________

☐ ☐ Sleep Apnea

☐ ☐ Other: ____________

-Liver / Kidneys-

☐ ☐ Kidney Disease

☐ ☐ Hepatitis / Jaundice

☐ ☐ Liver Disease

☐ ☐ Other: ____________

-Musculoskeletal-

☐ ☐ Arthritis / Back or Hip Problem

☐ ☐ Joint Replacement / Implant
Year: ____________

☐ ☐ Muscle Weakness / Paralysis

☐ ☐ Numbness / Tingling

☐ ☐ Other: ____________

YES NO

-Cardiovascular-

☐ ☐ Mitral Valve Prolapse

☐ ☐ Rheumatic Fever

☐ ☐ High / Low Blood Pressure

☐ ☐ High Cholesterol

☐ ☐ Abnormal Rhythm

☐ ☐ Peripheral Vascular Disease

☐ ☐ Blood Clots

☐ ☐ Leukemia or Anemia

☐ ☐ Blood Transfusion

☐ ☐ Bleeding Disorder

☐ ☐ Heart Disease

☐ ☐ Congestive Heart Failure

☐ ☐ Swollen Ankles

☐ ☐ Pacemaker / Defibrillator

☐ ☐ Heart Murmur

☐ ☐ Congenital Heart Lesions

☐ ☐ Heart Attack
Date: ____________

☐ ☐ Angina / Chest Pain

☐ ☐ Heart Valve Replacement

☐ ☐ Cardiac Stent

☐ ☐ Other: ____________

YES NO

☐ ☐ Cancer

☐ ☐ Stomach Trouble / Nausea

☐ ☐ Hiatal Hernia

☐ ☐ Gastric Reflux

☐ ☐ Hay Fever / Seasonal Allergies

☐ ☐ Radiation Therapy

☐ ☐ Glaucoma

☐ ☐ Recent Weight Loss / Gain

☐ ☐ Cold Sores

☐ ☐ Other: ____________

-Neurological-

☐ ☐ Fainting

☐ ☐ Epilepsy / Convulsions / Seizures

☐ ☐ Psychiatric Treatment / Anxiety / Depression / Other

☐ ☐ Stroke / Transient Ischemic Attack

☐ ☐ Cognitive Deficiencies

☐ ☐ Vertigo

☐ ☐ Other: ____________

-Women Only-

☐ ☐ Are you pregnant?

☐ ☐ Do you think you may be pregnant?

☐ ☐ Are you nursing?

☐ ☐ Are you taking Birth Control Pills?

I certify that I have read and understand the above. I affirm that the information contained in the form and any additional information that I may furnish is true and correct to the best of my knowledge.

Patient Signature: ____ Date: ______________