



Health History

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician/Specialty: _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? Excellent Good Fair Poor

- | DO YOU or HAVE YOU EVER HAD | | YES | NO | | YES | NO | |
|------------------------------------|---|--------------------------|--------------------------|-----------------|---|--------------------------|--------------------------|
| 1. | Hospitalization for illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | 26. | Osteoporosis/osteopenia, taking bisphosphonates | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | An allergic reaction to: | | | 27. | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| | Aspirin, ibuprofen, acetaminophen | <input type="checkbox"/> | <input type="checkbox"/> | 28. | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | 29. | Contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> | 30. | Head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| | Tetracycline | <input type="checkbox"/> | <input type="checkbox"/> | 31. | Epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | 32. | Neurological problems | <input type="checkbox"/> | <input type="checkbox"/> |
| | Local Anesthetic | <input type="checkbox"/> | <input type="checkbox"/> | 33. | Viral infections and/or cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| | Fluoride | <input type="checkbox"/> | <input type="checkbox"/> | 34. | Any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| | Metals (gold, stainless steel) | <input type="checkbox"/> | <input type="checkbox"/> | 35. | Hives, skin rash and/or hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| | Latex | <input type="checkbox"/> | <input type="checkbox"/> | 36. | Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| | Any other medications: _____ | | | 37. | Hepatitis (type _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | 38. | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 39. | Tumor, abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | 40. | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | 41. | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 42. | Emotional problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 43. | Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | A stroke | <input type="checkbox"/> | <input type="checkbox"/> | 44. | Antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Artificial prosthesis (heart valve or joints) | <input type="checkbox"/> | <input type="checkbox"/> | 45. | Alcohol/drug dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Anemia or other blood disorders | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 12. | Prolonged bleeding due to slight cut | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | YES | NO |
| 13. | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | 46. | Presently being treated for other illnesses | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | 47. | Aware of a change in your general health | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 48. | Taking medications for weight management | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Breathing or sleep problems (snoring, sinus) | <input type="checkbox"/> | <input type="checkbox"/> | 49. | Taking dietary supplements | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 50. | Often exhausted or fatigued | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | 51. | Subject to frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 52. | A smoker or smoked previously | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Thyroid or parathyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | 53. | Often unhappy or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | Hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 54. | WOMAN ONLY: taking birth control | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 55. | WOMAN ONLY: Pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 56. | WOMAN ONLY: Nursing | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Stomach or duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | 57. | MEN ONLY: Prostate disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Digestive disorders (gastric reflux) | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment:

List all medications, supplements and/or vitamins taken within the last 2-years. (Ask for an additional sheet if you are taking more than 8 medications).

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General Physician: _____ **Office Location:** _____ **Phone Number:** _____

*****Please advise us in the future of any changes in your medical history or of any medications you may be taking*****

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____