HEALTH HISTORY

Date: _____

Physician's Name: _____Telephone_____

To provide you with the safest and best care possible, please answer the following health questions. This is for our records and will be considered confidential.

1) Are you in good health? __ yes __ no
2) Have you had any serious illness, operation or been hospitalized? __ yes __ no
   If yes, please explain: _____
3) Do you take or have taken any *IV Bisphosphonates* for chemotherapy, ie. **Zometa** or *Oral Bisphosphonates* in the last 5 years for osteoporosis, i.e**., FosaMax** or **Actonel**, etc.? __ yes __ no
4) Are you on any blood thinners, i.e., **Coumadin**, **Plavix, Aspirin**? __ yes __ no
5) Do you need to be **pre-medicated** prior to dental treatment? __ yes __ no

List of Medications Currently Taking

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Have you had or do you currently have any of the following conditions?

Heart Condition

High or Low Blood Pressure	__ yes __ no
Angina/Chest Pain	__ yes __ no
Irregular Heart Beat	__ yes __ no
Heart Attack/Failure	__ yes __ no
Heart Bypass	__ yes __ no
Heart Pacemaker	__ yes __ no
Stroke	__ yes __ no
Rheumatic Fever	__ yes __ no
Heart Valve Damage	__ yes __ no
Anemia	__ yes __ no
Fainting	__ yes __ no

Liver Disease

Hepatitis (circle one) **A B C**

Breathing/Lung Condition

Asthma	__ yes __ no
Allergies/Hay Fever	__ yes __ no
Emphysema	__ yes __ no
Breathing Difficulties	__ yes __ no
Snoring/Sleep Apnea	__ yes __ no
Tuberculosis	__ yes __ no
Sinus Problems	__ yes __ no

Organ Conditions/Disease

Pancreas/Diabetes	__ yes __ no
Kidney/Dialysis	__ yes __ no
Eyes/Glaucoma	__ yes __ no
Thyroid	__ yes __ no
Neurologic/Epilepsy	__ yes __ no

Mental Health

Nervousness/Anxiety	__ yes __ no
Depression	__ yes __ no
Schizophrenia	__ yes __ no
Psychiatric Treatment	__ yes __ no

Immunosupressed/Blood Disease

HIV Positive/AIDS	__ yes __ no
Venereal Disease	__ yes __ no
Hemophilia	__ yes __ no

Joint Condition

Clicking/Pain in Jaw	__ yes __ no
Arthritis	__ yes __ no
Artificial Knee or Hip	__ yes __ no

Allergies

Penicillin or Amoxicillin	__ yes __ no
Any Other Antibiotics	__ yes __ no
Latex	__ yes __ no
Local Anesthetic	__ yes __ no
Sulfa Drugs	__ yes __ no
Codeine	__ yes __ no
Barbiturates	__ yes __ no
Ibuprofen/Aspirin	__ yes __ no

Other _____

Cancer *location:* _____

Surgery	__ yes __ no
Radiation Treatment	__ yes __ no
Chemo Therapy	__ yes __ no

Are you pregnant?	__ yes __ no
Are you breast feeding?	__ yes __ no
Are you taking birth control?	__ yes __ no

Other Conditions:

_____
_____
_____

I have filled out this health questionnaire completely. I have advised the doctor of all medical problems of which I am aware.

Signature of Patient, Parent, or Guardian: _____ **Date:** _____

Signature of Doctor: _____ **Date:** _____

Recall Review every 6 Months

Any changes in your Health History? __ yes __ no if yes, for what conditions? _____

Are you taking any NEW medications? __ yes __ no if yes, please list: _____

Signature of Patient, Parent, or Guardian: _____ **Date:** _____

Signature of Doctor: _____ **Date:** _____

Recall Review every 6 Months

Any changes in your Health History? __ yes __ no if yes, for what conditions? _____

Are you taking any NEW medications? __ yes __ no if yes, please list: _____

Signature of Patient, Parent, or Guardian: _____ **Date:** _____

Signature of Doctor: _____ **Date:** _____