



Patient Health History

Date _____

Patient Name _____ Age _____ Sex _____

Height ____ft. ____in. Weight _____lbs. Are you in good health?..... Yes No

Have there been any changes in your general health in the past year?..... Yes No

If so, explain _____

Are you under the care of a physician? Yes No

If so, for what are you being treated? _____ Date of last visit _____

The name, address and phone number of my physician is: _____

Have you had any illness, operation or been hospitalized in the past five years?..... Yes No

Do you have any unhealed injuries or inflamed areas in or around your mouth? Yes No

Do you have any growth or sore spots in your mouth? Yes No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...		Yes	No	Notes	HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...		Yes	No	Notes
1	Rheumatic fever?				28	Stroke?			
2	Heart valve problems /mitral valve prolapse?				29	Thyroid trouble?			
3	Heart Murmur?				30	Diabetes?			
4	Heart Problems?				31	Low blood sugar?			
5	High blood pressure?				32	Kidney trouble?			
6	Low blood pressure?				33	Are you on dialysis?			
7	Chest pain, angina?				34	Swollen ankles?			
8	Heart attack(s)?				35	Arthritis or joint disease?			
9	Irregular heart beat?				36	Stomach ulcers?			
10	Cardiac pacemaker?				37	Contagious diseases?			
11	Heart surgery?				38	Sexually transmitted diseases?			
12	Bronchitis, chronic cough?				39	Problems of the immune system?			
13	Asthma?				40	A tumor or growth?			
14	Hayfever/Sinus problems?				41	Mental health problems?			
15	Tuberculosis?				42	Removable dental appliances?			
16	Emphysema?				43	Are you on a diet?			
17	Difficulty breathing?				44	Eating disorder?			
18	Any other lung trouble?				45	Alcoholic beverages?			
19	Do you smoke?				46	Recreational drugs?			
20	Blood disorder such as anemia?				47	Contact lenses?			
21	Bruise easily?				48	Eye disease/Glaucoma?			
22	Bleeding tendency (abnormal bleed)?				49	Radiation/chemotherapy?			
23	Jaundice, hepatitis or liver disease?				50	Blood transfusion?			
24	Infectious mononucleosis?				51	Pain & clicking of jaws when eating?			
25	Gallbladder trouble?				52	Malignant Hyperthermia?			
26	Fainting spells?				53	TMJ Dysfunction?			
27	Convulsions, epilepsy?				54	HIV/AIDS?			

Names of Drugs Currently Taking:

Anticoagulants/Blood Thinners Yes No

Tranquilizers/Antidepressants Yes No

Cortisone/Prednisone Yes No

Antibiotics Yes No

Aspirin Yes No

Heart Medication Yes No

High blood pressure Medicine Yes No

Insulin or similar drug Yes No

Inhalers Yes No

Fosomax (Alendronate) , FosomaxD (Alendronate) , Bonifos (Clodronate) , Didronel (Etidronate) , Boniva (Ibandronate)

Aredia (Pamidronate) , Actonel (Risedronate) , Skelid (Tiludronate) , Zometa (Zoledronic Acid)

Other Yes No

Do you have any artificial joints in your body? Yes No

Are you allergic to or have you reacted adversely to any drug including penicillin, novocaine, aspirin or codeine?..... Yes No

Allergies other than drug allergies? (*i.e. latex gloves; please list*) _____ Yes No

Do you have any disease, condition or problem not listed above that you think we should know about? Yes No

If so, please explain _____

Have you had any serious problems with any previous dental treatment? Yes No

If so, explain _____

Have you or your family had any serious problems associated with general anesthesia or sedation? Yes No

If so, please explain _____

Have you ever bled excessively after a cut, wound or surgery? Yes No

If so, please explain.....

Women: Is there a possibility that you may be pregnant?..... Yes No

If so, estimated delivery date _____

Are you nursing?..... Yes No

Are you taking birth control pills? Yes No

Do you have any problems associated with your menstrual period?..... Yes No

If so, please explain _____

If you are completing this form for the patient, what is your relationship to the patient? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omission that I may have made in the completion of this form.

Signature of patient: _____ Date: _____

(Parent or Guardian if Minor)

Office Use Only

Reviewed by: _____

Date: _____