



Health History

Patient Name: _____ **Date of Birth:** _____

To our patients: Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have or medication that you may be taking may have an important bearing in the care that you will be receiving. Thank you for assisting us in providing you with the best possibly care by answering the following questions. Your answers will remain confidential.

Are you in good health? Yes No Height _____ Weight _____ Date of last physical exam: _____

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

Are you under the care of a physician for any condition(s)? Yes No Date of last visit: _____

If yes, for what condition(s) are you being treated? _____

Have you ever taken prescription medication for weight reduction (diet pills)? Yes No

Are you currently taking, or have you ever taken any of the following medications for the treatment of osteoporosis or cancer?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Fosamax (alendronate) | <input type="checkbox"/> Actonel (risedronate) | <input type="checkbox"/> Boniva (ibandronate) | <input type="checkbox"/> Ske lid (tilude ronate) |
| <input type="checkbox"/> Didronel (etidronate) | <input type="checkbox"/> Aredia (pamidronate) | <input type="checkbox"/> Zometa (zoledronic acid) | <input type="checkbox"/> NO |

Have you ever had, or do you currently have:

	Yes	No	Documents no test
Rheumatic Fever			
Damaged heart valve or artificial heart			
Mitral Valve Prolapse			
Heart Murmur			
High Blood Pressure			
Low Blood Pressure			
Chest pain or Angina			
Heart Attack			
Irregular Heart Beat			
Cardiac Pacemaker			
Open Heart Surgery or Angioplasty			
Swollen Ankles			
Bronchitis/Pneumonia			
Chronic cough			
Asthma			
Hay Fever/Sinus Problems			
Tuberculosis			
Emphysema			
Shortness of Breath			
Any other lung trouble			
Blood Disorders such as Anemia			
Do you bruise easily?			
Prolonged or heavy bleeding			
Jaundice, Hepatitis, Liver Disease			
Stomach Ulcers			
Gallbladder trouble			
Fainting Spells			
Convulsions, Seizures, Epilepsy			

	Yes	No	Documents no test
Stroke			
Thyroid Trouble			
Diabetes			
Low Blood Sugar			
Kidney Trouble			
Are you receiving Dialysis?			
Arthritis joint trouble			
Prosthetic(artificial) joint replacement			
Do you take a pre-medication?			
Contagious diseases			
Sexually transmitted diseases			
AIDS or HIV infection			
Have you have radiation or chemotherapy?			
Blood transfusion			
Cancer, tumor or other growth			
Depression or other mental problems			
Removable dental appliances			
Eye disease/Glaucoma			
Do you wear contact lenses?			
Pain or clicking of the jaw joints? (TMJ)			
Malignant Hyperthermia			
Reaction to anesthesia			
Physical impairment or disability			
Do you get frequent cold sores?			
Do you smoke?			
Do you drink alcoholic beverages?			
Do you used addictive drugs?			

