HEALTH HISTORY

Name**:** _____ Date: _____
Date of last health care exam: _____Name of Dr._____
Have you been hospitalized in the last 5 years? (Please circle) No Yes
If yes, reason:_____
Are you currently receiving care? No Yes If yes, nature of care: _____
Please list all the names and phone numbers of any other physicians who are currently providing you care:

1. _____
2. _____
3. _____

*For the following questions **circle** yes or no. Your answers are for our records only and will be confidential*

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Do you take Blood Thinners?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Emphysema or Lung Illnesses	No	Yes
Hypoglycemia?	No	Yes	Mental Disorders	No	Yes
Fainting or Dizzy Spells	No	Yes	Cancer or Tumor?	No	Yes
Previous Bacterial Endocarditis	No	Yes	Radiation or Chemo Treatment	No	Yes
Heart Surgery (Valve, Bypass, or Transplant)	No	Yes	Rheumatic Fever	No	Yes
Congenital Heart Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes
Heart Disease, Heart Attack	No	Yes	Epilepsy	No	Yes
Do You Have A Pacemaker	No	Yes	Fibromyalgia	No	Yes
Heart Stent? When placed?	No	Yes	Alcohol or Drug Abuse Treatment?	No	Yes
Do you have Sinus Problems?	No	Yes	Glaucoma	No	Yes
Do you have abnormal headaches?	No	Yes	Other Illnesses:	No	Yes

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?	No	Yes

Please list any other medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
What is your normal blood pressure?: _____/_____

Are you **allergic** or have you had a reaction to medications or substances No Yes
If so, please list here:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) *Responsible Party Signature* *Date*