Name Last: _______________________First: ___________________ Middle: _______________ Date: __________

HEALTH HISTORY

Primary Care physician's Name: ____ Telephone Number:_____ - _________________

Weight____________ **Height**____________ PLEASE **MARK** ANY OF THE FOLLOWING WHICH YOU HAVE HAD

☐ Abnormal Bleeding	☐ Acid Reflux Disease	☐ AIDS / HIV Positive	☐ Allergies/Sinus Problems
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Blood Disorder
☐ Blood Pressure High	☐ Blood Pressure Low	☐ Cancer	☐ Chemical Dependency
☐ Chemotherapy	☐ Colitis	☐ Diabetes Insulin Use	☐ Diabetes oral medications
☐ Difficulty Breathing	☐ Fainting Spells / Dizziness	☐ Glaucoma	☐ Heart Attack
☐ Heart Murmur	☐ Heart Trouble	☐ Heart Valve Replacement	☐ Hepatitis/Liver Disease
☐ Hives/Skin Rash	☐ Immune Disorder	☐ Kidney Trouble	☐ Knee or Hip Replacement
☐ Low Blood Sugar	☐ Mitral Valve Prolapse	☐ Pace-Maker	☐ Psychiatric Disorder
☐ Radiation Treatment	☐ Rheumatism	☐ Rheumatic Fever	☐ Seizures
☐ Sickle Cell Anemia	☐ Stomach Ulcers	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Vision Problems	☐ Contact lenses	
Have you ever used: ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Zomeda Ask about complications with these medications and oral surgery	**Do you use:** ☐ Antibiotics ☐ Aspirin ☐ Blood Thinners (Coumadin) ☐ Steroids	**Do you:** ☐ Smoke How much per day______ , for ____ years ☐ Chew Tobacco ☐ Drink Alcohol How often _________________	**PRE_MEDICATION:** Do you need to be pre-medicated with antibiotics for dental procedures? ☐ Yes ☐ No ☐ Not sure

ALLERGIES
List all medication or food

☐ **Penicillin** ☐ Sulfa Drugs ☐ Local Anesthesia ☐ Aspirin or NSAIDS
☐ Codeine ☐ Other ☐ **Latex** ☐ Eggs

WOMEN ONLY:
☐ Entered Menopause
☐ Birth Control Pill

List other allergies

Adverse Reactions (ie. Nausea, Vomiting, Dizziness)
☐ Hydrocodone ☐ Motrin / Ibuprofen
☐ Codeine ☐ Other:

ARE YOU PREGNANT, OR IS THERE ANY CHANCE YOU MIGHT BE PREGNANT?
☐ Yes ☐ No
☐ Nursing
☐ Weeks Pregnant _______

☐ **TMJ Problems**
☐ Clicking ☐ Popping
☐ Grinding ☐ Painful opening

Do you want to talk to the Doctor privately?
☐ Yes Would you like family or your company to leave the room? ☐ Yes ☐ No

Office Notes:

CURRENT MEDICATION:

____

OTHER CONDITIONS: Do you have any diseases, conditions or problems not listed above? ☐ Yes ☐ No

____

SURGERIES: Have you been hospitalized or had any surgeries? ☐ Yes ☐ No If yes, please explain:

______________________________________ ______________________
Signature of Patient (or Parent if patient is a minor) Date

______________________________________ ______________________
Signature of Doctor Date

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