Patient Health History

Name you wish to be called:_____

Patient Legal Name:_____ **Today's Date**_____ **Age:**_____

Medical	Yes	No	Explain
1. Are you in pain at this time?			
2. Are you in poor health generally?			
3. Are you currently under the care of a physician?			Date of last medical exam
Physician Name: _____			
4. Are you currently taking any medications?			*If yes please list on back*
5. Have you been hospitalized or had any surgeries?			Complications:
6. Are you currently diagnosed as having any disease or illness?			
7. Chief complaint:			

Medical History	Yes	No		Yes	No		Yes	No
Abnormally high or low blood pressure			Kidney problems			Artificial joints		
Heart disease or a heart attack			Liver problems			Tuberculosis (Tb)		
Congestive heart failure			Stroke			Persistent cough		
Treatment for cancer			Sickle cell anemia			Frequent, severe headache		
Have you ever been jaundiced?			Anemia			Emphysema		
Angina (pain in chest under exertion)			Osteoporosis			Hemophilia		
Heart murmur current( ) child ( ) pregnant( )			Bruise easily			Venereal disease		
Alcohol or drug dependency			Sinus problems			Skin disease		
Rheumatic fever or scarlet fever			Allergies/Hay Fever			Arthritis		
Stomach or intestinal ulcers			HIV positive or AIDS			Tobacco use		
Diabetes/Relative with diabetes			Asthma			Recreational drug use		
Thyroid problems (overactive or underactive)			Seizure disorders/epilepsy			Migraine		
Abnormal bleeding following dental procedure			Glaucoma			Headaches		
Treatment for nervous or emotional difficulties			Hip or Knee replacement			Mitral Valve Prolapse		
Cortisone treatment (of more than 2 weeks duration, and within the last 2 years)			Artificial heart valve / pacemaker			Swollen ankles or out of breath upon exertion		
Hepatitis: Circle Type (A Infectious) (B Serum, blood borne) C (Non-A Non-B) Other			High stress lifestyle or occupation			Taking any bisphosphonates for osteoporosis or cancer (See back for list)		
			Dementia / Alzheimers					

Drug Allergies or Sensitivities						Females Only	Yes	No
Penicillin (including Amoxicillin, Ampicillin, etc.)			Erythromycin			Pregnant –months:		
Aspirin or aspirin compounds (Motrin, Naprosyn)			Codeine or Demerol			Breast Feeding		
Local Anesthetics (Lidocaine, Xylocaine, Novocaine, Articaine)			Tetracyclines			Usage of oral contraceptives		
Other drugs not mentioned here:						Problems with menstrual cycle		

Dental History	Yes	No		Yes	No		Yes	No
Please indicate whether or not you now have or ever had any of the following:								
Areas where food tends to pack			Clenching or grinding teeth			Gum swelling and boils		
Fever blisters or sores in mouth or on lips			Head, neck or jaw injuries			Bad taste or odor from mouth		
Teeth sensitive to hot, cold or sweets			Difficulty in opening or closing			Gums bleed when you brush		
Burning sensation of tongue, lips, gums, inside cheek			Jaw out of joint			Sore mouth		
Previous periodontal (gum) treatment			Difficultly in chewing			Painful teeth and gums		
Have you ever experienced an adverse reaction during or in conjunction w/medical or dental procedure?			Pain in jaw joint, ear, side of face			Jaw ever click or pop		
			Wake up with sore jaw or facial muscles			Previous orthodontic treatment		

How do you feel about the appearance of your teeth?_____

Other information about your dental health or previous treatment_____

Patient's Signature_____

Please List Medications			
Medication Name	Doctor/Phone Number	Prescribed For	Dose/Time Taken

List of bisphosphonates
Alendronate (Fosamax)
Risedronate (Actonel)
Etidronate (Didronel)
Ibandronate (Boniva)
Pamidronate (Aredia)
Zoledronate (Zometa)
Zoledronic Acid (Reclast)