Patient Health History

Name:_____SS#:_____Date of Birth:_____

Address:_____City/State/Zip:_____

Phone(H):_____Cellular Phone:_____Phone(W):_____

E-mail Address:_____Employer:_____

Dental Insurance:_____Policy Plan:_____Effective Date:_____

Physician:_____Address Phone:_____

General Health: Excellent Good Fair Poor Last Full Physical:_____Findings:_____

Drug Allergies/ Reactions:_____

Current Medications:_____

Emergency Contact:_____Phone:_____Referred By:_____

Do you currently have, or have you been treated in the past for any of the following:

Heart disease……..……	YES____ NO____	Asthma/hayfever…….....	YES____NO____
Heart surgery……..……	YES____ NO____	Sinus trouble…….. …..… …	YES____NO____
Rheumatic fever……	YES____ NO____	Cough(persistent)……...…….	YES____NO____
Abnormal blood pressure……..	YES____ NO____	Jaundice……..……..….	YES____NO____
Ulcers……..……	YES____ NO____	Arthritis……..……..….	YES____NO____
Tuberculosis/lung disease…….	YES____ NO____	Stroke……..……...	YES____NO____
Diabetes…….	YES____ NO____	Glaucoma……..…….	YES____NO____
Epilepsy…….	YES____ NO____	Hip/joint replacement….....	YES____NO____
Anemia……	YES____ NO____	Is your diet adequate….……..	YES____NO____
Congenital heart defects…….	YES____ NO____	Do you take vitamins?.....	YES____NO____
Heart murmur…….	YES____ NO____	Surgical treatment…….	YES____NO____
Psychological/emotional disorder..	YES____ NO____	(if YES, please describe)_____	
Received IV Aredia/Zometa……...	YES____NO____	_____	

Do you have, or have you been exposed to any of the following:

Hepatitis…….	YES____NO____	Herpes……	YES____NO____
HIV (AIDS virus)……	YES____NO____		

Have you ever had a blood transfusion…….	YES____NO____
Have you ever been diagnosed with cancer……..	YES____NO____
Have you had radiation/chemotherapy…….….	YES____NO____
Do you have any chemical dependencies……	YES____NO____
Are you subject to prolonged bleeding……	YES____NO____
Have you ever been treated for a bleeding problem..	YES____NO____
Are you subject to fainting spells…….	YES____NO____
(Women) Are you pregnant or nursing……	YES____NO____ (if yes, due date? _____)
Do you smoke?	YES____NO____ (if yes, how much?_____)

I certify that all information above is true and correct to the best of my knowledge. I further certify that I will make office aware of any changed in my medical history prior to receiving treatment.

_____/_____ _____/_____

Patient Signature Date Doctor Signature Date