# welcome to our practice

## *Confidential Health History*

Patient Name: _____ BOB: _____

- Is your general health good? if No, please explain _____
- Have you been under the care of a physician in the past year? Yes / NO
  if yes, for what condition are you being treated? _____
- Have you had any major illness, operation or been hospitalized? Yes / NO
  if Yes, please explain _____

_____

## Have you or do you currently have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Rheumatic fever | ☐ Yes | ☐ No | Snoring /sleep apnea |
| ☐ Yes | ☐ No | Heart valves /mitral valve prolapse | ☐ Yes | ☐ No | Asthma /hay fever |
| ☐ Yes | ☐ No | Chest pain /angina | ☐ Yes | ☐ No | Sinus problem |
| ☐ Yes | ☐ No | Irregular heat beat | ☐ Yes | ☐ No | Emphysema or other lung disease |
| ☐ Yes | ☐ No | Cardiac pacemaker | ☐ Yes | ☐ No | Bronchitis, chronic cough |
| ☐ Yes | ☐ No | Heart attack | ☐ Yes | ☐ No | Tuberculosis |
| ☐ Yes | ☐ No | Heart surgery | ☐ Yes | ☐ No | Respiratory problems |
| ☐ Yes | ☐ No | Heart disease/defects | ☐ Yes | ☐ No | Bronchitis |
| ☐ Yes | ☐ No | Sickle cell disease | ☐ Yes | ☐ No | Fainting spells |
| ☐ Yes | ☐ No | Leukemia | ☐ Yes | ☐ No | Thyroid disease |
| ☐ Yes | ☐ No | Anemia | ☐ Yes | ☐ No | Diabetes |
| ☐ Yes | ☐ No | Bleeding problems/ Bruise easily | ☐ Yes | ☐ No | kidney or bladder disease |
| ☐ Yes | ☐ No | High blood pressure | ☐ Yes | ☐ No | are you on dialysis |
| ☐ Yes | ☐ No | Low blood pressure | ☐ Yes | ☐ No | Liver disease |
| ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No | Hepatitis/jaundice |
| ☐ Yes | ☐ No | Arthritis/Rheumatism | ☐ Yes | ☐ No | Dry mouth |
| ☐ Yes | ☐ No | Swollen ankles /arthritis/joint disease | ☐ Yes | ☐ No | Stomach ulcers/acid reflux |
| ☐ Yes | ☐ No | Artificial joint | ☐ Yes | ☐ No | Tumors or Cancer |
| ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Radiation therapy |
| ☐ Yes | ☐ No | Fainting /Seizures | ☐ Yes | ☐ No | Chemotherapy |
| ☐ Yes | ☐ No | Epilepsy / Convulsions | ☐ Yes | ☐ No | Immune system compromise |
| ☐ Yes | ☐ No | Eye disease /Glaucoma | ☐ Yes | ☐ No | Herpes |
| ☐ Yes | ☐ No | Transplants | ☐ Yes | ☐ No | Skin disease |
| ☐ Yes | ☐ No | Psychiatric care | ☐ Yes | ☐ No | Canker or cold sores |
| ☐ Yes | ☐ No | Recent significant Weight Loss | ☐ Yes | ☐ No | AIDS/HIV |
| | | | ☐ Yes | ☐ No | Sexually transmitted disease |

## ARE YOU TAKING OR HAVE YOU TAKE

☐ Yes ☐ No Blood thinners ( e.g. Coumadin, Plavix, Aspirin, Actonel) , please list _____

☐ Yes ☐ No Osteoporosis or bone density medication( Acedia, Zometa, Fosamax, Actonel, Reclast, Boniva, Aredia, ) ?
please list _____

☐ Yes ☐ No herbal supplement, homeopathic formulation or diet pills (Fen-phen)? please list _____

_____

## Are You Allergic or had a reaction to any of the following?

□Yes □No Aspirin
□Yes □No Penicillin/Amoxicillin
□Yes □No Other antibiotics. please list_____
□Yes □No Latex
□Yes □No Local anesthetics
□Yes □No Metal
□Yes □No Codeine or other narcotics.
□Yes □No Iodine
□Yes □No Other, please list_____

## Please list any medications you are currently taking

| | |
|---|---|
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| | |
| | |

## Female patients

□Yes □No Are you, or could you be pregnant? If yes, expected delivery date _____
□Yes □No Are you nursing?
□Yes □No Are you taking birth control pills?

## SOCIAL HABITS

□Yes □No Do you smoke or chew tobacco? if yes how much? _____
□Yes □No Do you drink alcoholic beverages? if yes how much ?_____
□Yes □No Do you use any illicit drugs?

## Is there any other condition concerning your health that the Doctor should be aware of ?

_____

_____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

_____ _____

**Signature of Patient ( Parent or Guardian)** **Date**