Date____________

HEALTH HISTORY FORM

Please fill out all of the information below so we can better serve you!

PATIENT'S NAME: ________________________________ **DATE OF BIRTH:** _________________________

Have you been seen by a medical doctor or changed medications over the past 2 years? [ ] Yes [ ] No

If yes, what were you seen for or what medication changed: ____

Some dental procedures require premedication before treatment; have you ever had a total joint replacement (hip, knee, etc) valvular heart disease (prosthetic cardiac valve, congenital heart disease, etc.) or infective endocarditis? [ ] Yes [ ] No

If yes, which procedure or condition and when? ____

Some surgical procedures require the care of an oral surgeon; have you ever taken a bis-phosphonate (ex. Fosamax), currently taking any blood thinners, or have previously been treated with head or neck radiation? [ ] Yes [ ] No

If yes, which medication have you taken? ____

Are you aware of any allergies to any medications (i.e. penicillin) or substances (i.e. latex)? [ ] Yes [ ] No

If yes, what are you allergic to? ____

For women; Is there any possibility you are pregnant or are you currently nursing? [ ] Yes [ ] No **How many months?** ____

MEDICATIONS

Please accurately record all medications you are taking or provide a copy of your medication list

1)	4)	7)
2)	5)	8)
3)	6)	9)

FAMILY AND SOCIAL HISTORY

Family history of SYSTEMIC DISEASE (i.e. Diabetes, Heart Disease, High Blood Pressure, Cancer)? [ ] Yes [ ] No

If yes, which system disease? ____

Family history of DENTAL DISEASE (i.e Periodontal Disease, High Cavity Risk) [ ] Yes [ ] No

If yes, which dental disease? ____

Do you use, or have you in the past, used any of the following products?

Tobacco	[ ] Yes	[ ] No	If you please list how much/often or previous history?
Alcohol	[ ] Yes	[ ] No	________________________________
Recreational Drugs	[ ] Yes	[ ] No	________________________________

What was your last recorded blood pressure? ______________________ **If diabetic, what was your last HbA1c?** _________________

Date____________

HEALTH HISTORY FORM

Please fill out all of the information below so we can better serve you!

REVIEW OF SYSTEMS

Do you have trouble with or have you been diagnosed with any of the following?

Ear, Nose, Mouth, Throat		
Hearing loss	Yes	No
Sinus Problems	Yes	No
Chronic Cough	Yes	No
Vertigo	Yes	No
Dry Mouth	Yes	No
Laryngitis	Yes	No
Other _____________	Yes	No

Neurological		
Tumor	Yes	No
Stroke/CVA	Yes	No
Migraines	Yes	No
Facial Pain	Yes	No
Seizures/Epilepsy	Yes	No
Other _____________	Yes	No

Psychiatric		
Depression	Yes	No
Anxiety	Yes	No
Other _____________	Yes	No

Respiratory		
Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No
Sleep Apnea	Yes	No
Short of Breath	Yes	No
Other _____________	Yes	No

Cardiovascular		
High Blood Pressure	Yes	No
Stroke/CVA	Yes	No
Heart Disease	Yes	No
Heart Murmur	Yes	No
Chest Pain	Yes	No
Irregular Rhythm	Yes	No
Artificial Valve	Yes	No
Rheumatic Fever	Yes	No
Heart Attack	Yes	No
Pacemaker	Yes	No
Other _____________	Yes	No

Gastrointestinal		
Crohn's Disease	Yes	No
Ulcers	Yes	No
Nausea/Vomiting	Yes	No
Heartburn/Reflux	Yes	No
Other _____________	Yes	No

Genitourinary		
Kidney Disease	Yes	No
Hepatitis A B C	Yes	No
HIV/AIDS	Yes	No
Herpes	Yes	No
HPV	Yes	No
Other _____________	Yes	No

Cancer	Yes	No
What Type: _________________		

Musculoskeletal		
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Gout	Yes	No
Artificial Joints	Yes	No
Other _____________	Yes	No

Integumentary/Skin		
Eczema	Yes	No
Psoriasis	Yes	No
Herpes Simplex	Yes	No
Other _____________	Yes	No

Endocrine		
Diabetes Type 1	Yes	No
Diabetes Type 2	Yes	No
Thyroid Dysfunction	Yes	No
Other _____________	Yes	No

Hematologic/Lymphatic		
Anemia	Yes	No
Bleeding Problems	Yes	No
High Cholesterol	Yes	No
Other _____________	Yes	No

Allergic/Immunologic		
Drug Allergies	Yes	No
Rheumatoid Arthritis	Yes	No
Sjogren's Syndrome	Yes	No
Other _____________	Yes	No

Do you have any other medical conditions or concerns that are not listed above? [ ] Yes [ ] No

If yes, 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 any change in my health or medication.

Patient/Guardian Signature: ____ **Date:** ________________

Medical History Review:

Dentist Signature: ____ **Date:** ________________