***Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.***

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any changes in your general health in the past year? ­­ Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now under a doctor’s care for a particular problem at this time? Yes No

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT MEDICAL HISTORY**  **Do you have or have you ever had:** |  |  |  |  |  |
| Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? | Yes | No | Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? | Yes | No |
| Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? | Yes | No | Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? | Yes | No |
| Kidney disease or kidney failure, requiring dialysis? | Yes | No | Liver disease (jaundice, hepatitis A, B, or C)? | Yes | No |
| Thyroid disease? | Yes | No | Arthritis? | Yes | No |
| Stomach ulcers or colitis? | Yes | No | Significant weight loss or gain? | Yes | No |
| Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? | Yes | No | Seizures, convulsions, epilepsy, fainting or dizziness? | Yes | No |
| Frequent or recurring mouth sores? | Yes | No | Sinus or nasal problems? | Yes | No |
| Glaucoma? | Yes | No | Sleep apnea? | Yes | No |
| Diabetes? | Yes | No | Osteoporosis or osteopenia? | Yes | No |
| Any cancer, radiation, or chemotherapy? Yes No  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of your last treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No  If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| **FAMILY MEDICAL HISTORY**  **Do you have a family history of any of the following? If yes, indicate the relationship.** | |
| Diabetes? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cancer? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart disease? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Bleeding problems? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tumors? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep Apnea? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Lung disease? Yes No Relationship \_\_\_\_\_\_\_\_\_\_\_\_ |
| **FEMALE PATIENTS**  Are you pregnant, or is there any chance you might be pregnant? Yes No | |

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| **MEDICATIONS**  **Are you using any of the following:** |  |  |  |  |  |
| Antibiotics? | Yes | No | Prescription pain medication? | Yes | No |
| Anticoagulants (blood thinners)? | Yes | No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes | No |
| Heart medications? | Yes | No | Insulin or oral anti-diabetic drugs? | Yes | No |
| Steroids (cortisone, prednisone, etc.)? | Yes | No | Blood pressure medications? | Yes | No |
| Antianxiety agents, antidepressants or other psychiatric medications? | Yes | No | Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
| Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:   |  |  |  |  | | --- | --- | --- | --- | | **Medication** | **Dosage** | **Medication** | **Dosage** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | |

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| **ALLERGIES**  **Are you allergic to or have you had an adverse reaction to:** | |
| Latex? Yes No | Codeine or other pain killers? Yes No |
| Food products? Yes No | Aspirin, Motrin, Aleve, or ibuprofen? Yes No |
| Sedatives, barbiturates? Yes No | Penicillin or other antibiotics? Yes No |

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other drug or food allergies not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SOCIAL HISTORY** | | |
| Have you ever smoked, vaped or chewed tobacco? Yes No | If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Have you ever sought professional care or been hospitalized for:** | | **Do you use:** |
| Substance abuse? Yes No | | Alcohol? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emotional disorders? Yes No  Alcoholism? Yes No | | Marijuana? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ Recreational drugs? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DENTAL HISTORY** | | |
| Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you wish to talk to the doctor privately about anything? Yes No | | |

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

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Signature of patient, parent, guardian Date

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Printed name of patient, parent, guardian/Relationship Doctor’s Signature

**HEALTH HISTORY UPDATE**

Date Comments Doctor’s Signature

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