

Health History

Name: _____ Date of Birth: _____

Do you currently have or have you EVER had any of the following:

- Heart Murmur (Mitral Valve Prolapse)
- Artificial Joints: Hip Knee Other _____
Please circle
Date of surgery: _____
- Rheumatic Fever
- Take Diet Pills—Fen-Phen or other
- Artificial Heart Valve
- Had Infective Endocarditis
- Congenital Heart Condition
- Been told to **PREMEDICATE** before a dental procedure __Yes __No
If yes, please explain: _____

- HIV Positive/AIDS Related Complex
- Tuberculosis
- Hepatitis: A B C Other _____
Please circle
- Jaundice
- Liver Disease
- Blood Transfusion Date: _____

- Pregnant/Due Date: _____
- Nursing Mother
- Taking Birth Control Pills

- Stroke
- Heart (Disease, Surgery, Attack)
- High Blood Pressure---What is your usual reading? ____/____
- Blood Thinning Medication
- Low Blood Pressure
- Pacemaker
- Pacemaker with a Difibulator
- Stents
- Abnormal Heart Condition

- Acid Reflux
- Take Antiacids
- Take Tagamet (Cimetidine)
- Stomach Problems

- Bowel Disorders
- Eating Disorders _____

- Arthritis
- Rheumatoid Arthritis
- Diabetes
- Lupus
- Sjogren's Syndrome
- Other Autoimmune Disease: _____
- Glaucoma
- Blood Disorders
- Abnormal Bleeding from a cut
- Anemia
- Fainting
- Dizziness
- Seizures
- Epilepsy
- Head Injuries
- Nervous Disorders
- Mental Disorders
- Kidney Disease
- Venereal Disease: List: _____
- HIV Infection/AIDS
- Recurrent Illnesses
- Other Infections List: _____
- Slow Healing Mouth Sores

- Respiratory Problems
- Emphysema
- Asthma
- COPD
- Sinus Problems
- Hay fever

- Osteoporosis
- Osteopenia

- Cancer Type: _____ Date diagnosed: _____
- Chemotherapy
- Radiation Therapy
- Oncologist Name and Phone number: _____
- Benign Growths/Tumors
- Previous Biopsies
- Sore/Enlarged Lymph Nodes

- Alcohol _____ Drinks per week
- Tobacco __Cigarettes ___packs per day/week **Circle day or week**
 __Smokeless ___ cans per day/week **Circle day or week**
- Illegal Drugs: _____
- Controlled Substance: _____

Allergies:

Codeine Penicillin LATEX Aspirin Valium or other sedatives
 Metal Local Anesthetics

Please circle all that applies

Other Medications: _____

Environmental: _____

Foods: _____

Do you take *or* have you ever taken any of the following medications:
 Please list date you started *and/or* stopped the medication.

Actonel (risedronate sodium)

Dosage and frequency: _____ Start Date: _____ Stop Date: _____

Fosamax (alendronate)

Dosage and frequency: _____ Start Date: _____ Stop Date: _____

Boniva (ibandronate)

Dosage and frequency: _____ Start Date: _____ Stop Date: _____

Do you consume grapefruit juice, grapefruits, or grapefruit extract? Yes No

Please list **ALL** current medications that you take. This includes all **Prescriptions, Over the Counter, Supplements, and Vitamins.** Please list the dosage and frequency.

Date of last health care exam: _____ What was it for? _____

Have you been admitted to a hospital or needed emergency care in the past five years?
 __Yes __No If yes, please explain _____

Are you now under the care of a physician? __Yes __No

If yes, please explain _____

Name and phone number of any physician you are currently receiving care from:

Do you have any health problems not previous listed or that need further clarification?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment with out fail.

Signature of patient, parent, or guardian

Date

Signature of doctor

Date