Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Gender: _____ Height: _____ Weight: _____

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:_____

Date of surgery:_____ Reason for surgery:_____

Date of surgery:_____ Reason for surgery:_____

Patient Medical History

Do you have or have you ever had:	Yes	No
Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	☐	☐
Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	☐	☐
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	☐	☐
Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	☐	☐
Kidney disease or kidney failure, requiring dialysis?	☐	☐
Liver disease (jaundice, hepatitis A, B, or C)?	☐	☐
Thyroid disease?	☐	☐
Diabetes?	☐	☐
Arthritis?	☐	☐
Glaucoma?	☐	☐
Stomach ulcers or colitis?	☐	☐
Significant weight loss or gain?	☐	☐
Seizures, convulsions, epilepsy, fainting or dizziness?	☐	☐
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	☐	☐
Sinus or nasal problems?	☐	☐
Sleep apnea?	☐	☐
Osteoporosis or osteopenia?	☐	☐
Any cancer, radiation or chemotherapy?	☐	☐

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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: _____

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 _____ Lung disease? ☐ Yes ☐ No Relationship _____

Sleep Apnea? ☐ Yes ☐ No Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? ☐ Yes ☐ No

MEDICATIONS

Are you using any of the following:

	Yes	No		Yes	No
Antibiotics?	☐	☐	Prescription pain medication?	☐	☐
Anticoagulants (blood thinners)?	☐	☐	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	☐	☐
Heart medications?			Insulin or oral anti-diabetic drugs?	☐	☐
Steroids (cortisone, prednisone, etc.)?	☐	☐	Blood pressure medications?	☐	☐
Antianxiety agents, antidepressants or other psychiatric medications?	☐	☐	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	☐	☐

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: _____

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:

Substance abuse?	☐ Yes	☐ No
Emotional disorders?	☐ Yes	☐ No
Alcoholism?	☐ Yes	☐ No

Do you use:

Alcohol?	☐ Yes	☐ No	How often? _____
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.

_____ _____
Signature of patient, parent, guardian Date

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

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature