



Health History

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:

Are you now under a physician's care for a particular problem currently? Why? _____
Have you ever been hospitalized or had a serious illness? Why? _____
Are you taking any medication? What medication? _____

Medical History:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?

Kidney disease or kidney failure, requiring dialysis?

Thyroid disease?

Stomach ulcers or colitis?

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?

Frequent or recurring mouth sores?

Radiation to the head or neck for cancer treatment?

Any disease, chemotherapy or transplant operation?
Cancer?

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?

Glaucoma?

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?

Liver disease (jaundice, hepatitis A, B, or C)?

Diabetes?

Arthritis?

Significant weight loss or gain?

Seizures, convulsions, epilepsy, fainting or dizziness?
Sinus or nasal problems?

Osteoporosis or osteopenia?

Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
If yes, please explain: _____

Allergies:

Are you allergic to or have you had an adverse reaction to:

Latex?
Food products? Wich ones? _____
Sedatives, barbiturates?

Codeine or other pain killers?
Aspirin, Motrin, Aleve, or ibuprofen?
Penicillin or other antibiotics?

Has you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

Social History:

Do you use any :

Drugs How often? _____
Alcohol How often? _____
Marijuana How often? _____

Female Patients:

Are You Pregnant?
How many months?
Due date: _____

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