

HEALTH HISTORY

Age _____

Weight _____

Please circle any of the following conditions which have ever applied to you.

Heart attack	Stroke	Alcoholism	Liver disease	Hiatal hernia
Heart disease	Rheumatic fever	Anemia	Kidney disease	Contagious disease
High blood pressure	Asthma	Hepatitis	Lung disease	Epilepsy
Chest pain (angina)	Emphysema	Jaundice	Cancer	Arthritis
Shortness of breath	Diabetes	Artificial joints	Radiation treatment	Psychiatric problems
Heart murmur	Glaucoma	Artificial valves	Chemotherapy treatment	Gastric Reflux
Blocked Arteries	Allergies			

Yes/No Do you have a family physician? If yes, physician's name _____

Yes/No Have you been under the care of a physician during the last five years?

Yes/No Have you ever been treated in an emergency room?

Yes/No Within the past 10 years, have you been admitted as a patient to a hospital?

Yes/No Are you allergic to latex, penicillin, codeine, aspirin, local anesthesia, barbiturates, pentothal, or any other drugs, any foods (i.e. soy, eggs, sulfites)

Yes/No Have you ever had heart problems? () High Blood pressure () Low pressure
() Heart Attack () Chest Pain (angina) () Irregular Heart Beat
() Heart Murmur () Rheumatic Fever () Other Cardiac Problems

Yes/No Do you have to take antibiotics to protect your heart, artificial joints, or for any other reason before dental work or oral surgery?

Yes/No Do you have or have you recently had a cold or respiratory problems?

Yes/No Have you ever been told you have: () Asthma (last time seen emergency room or Dr's office _____) () Bronchitis () Pneumonia () Cough
() Tuberculosis () Emphysema () Sleep Apnea / Sleep Disorder

Yes/No Have you had any other illness not listed above? _____

Yes/No Have you or any family member ever had difficulty with general anesthesia?

Yes/No Have you ever taken prednisone, cortisone or other steroid medicines?

Yes/No Have you had bleeding problems following dental surgery?

Yes/No Have you used any alcohol or drugs (recreational or street) in the past 72 hours? If yes, please check: () Alcohol
() Marijuana () Cocaine () Barbiturate () Heroin () Amphetamines () Other _____
Undisclosed use of these drugs can be extremely dangerous if you have a general anesthetic.

Yes/No Do you have a history of chemical dependency? If yes, how long have you been in recovery? _____

Yes/No Do you smoke? How many packs per day? _____ppd

Yes/No Are you wearing dentures? Yes/No Contact lenses?

(Women) Are you pregnant? _____ How many months? _____ Are you nursing? Yes/No

'PLEASE COMPLETE REVERSE SIDE'

Yes/No Do you take any medications, herbal remedies, or supplements on a regular or occasional basis? List medications:

Yes/No Have you ever received chemotherapy for cancer? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

Yes/No Are you **currently** taking Fosamax,Actonel/Boniva? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

When did you start taking the medication? _____

Yes/No Have you **ever** taken Fosamax,Actonel/Boniva? If yes, physician prescribing _____
Medication name: _____ Dosage / Frequency _____

When did you start taking the medication? _____

Medical Notes: _____

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

Signed _____ Date _____

If you completed this form for the patient what is your relationship to the patient? _____
