Health History Date:_____

_____ _____ _____ ☐Male ☐Female

Patient First Name Last Name Birthdates

1. Have you had any serious illness, operation or hospitalization? ☐Yes ☐No

_____

2. Are you under a physician's care at this time? ☐Yes ☐No

_____ _____ _____

Physician Name Address Phone

Do you have or did you ever have any of the followings?

Caridovascular Health

3. High blood pressure ☐Yes ☐No
4. Angina or heart attack ☐Yes ☐No
5. Chest pain on physical exertion ☐Yes ☐No
6. Coronary artery treatment (bypass, stent, etc.) ☐Yes ☐No
7. Heart valve replacement ☐Yes ☐No
8. Heart murmur ☐Yes ☐No
9. Heart disease, problem or treatment ☐Yes ☐No
10. Rheumatic fever ☐Yes ☐No
11. Past use of Fen-Phen ☐Yes ☐No
12. Irregular heart beat or pacemaker ☐Yes ☐No
13. Difficulty breathing when lying down ☐Yes ☐No
14. Stroke ☐Yes ☐No
15. Low blood pressure ☐Yes ☐No

Respiratory Health

16. Asthma ☐Yes ☐No
17. Emphysema or respiratory problems ☐Yes ☐No
18. Chronic sinus problem ☐Yes ☐No
19. Tuberculosis or persistent cough ☐Yes ☐No

Endocrine/Blood/Immune Health

20. Diabetes ☐Yes ☐No
21. Frequent thirst or urination ☐Yes ☐No
22. Thyroid problem ☐Yes ☐No
23. Abnormal bleeding, bruise easily ☐Yes ☐No
24. Hemophilia ☐Yes ☐No
25. Anemia/blood disease ☐Yes ☐No
26. Cancer ☐Yes ☐No
27. Radiation therapy/chemotherapy ☐Yes ☐No
28. HIV infection/AIDS ☐Yes ☐No
29. Cold sores/canker sores ☐Yes ☐No
30. Organ transplant ☐Yes ☐No
31. Blood transfusion ☐Yes ☐No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐Yes ☐No
33. Arthritis ☐Yes ☐No
34. Osteoporosis ☐Yes ☐No
35. Fainting spells or dizziness ☐Yes ☐No
36. Seizures ☐Yes ☐No
37. Numbness or muscle weakness ☐Yes ☐No
38. Multiple sclerosis ☐Yes ☐No
39. Mental retardation ☐Yes ☐No
40. Dementia/Alzheimer's disease ☐Yes ☐No
41. Anxiety/Nervousness ☐Yes ☐No
42. Mental health treatment ☐Yes ☐No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A,B,C or other) ☐Yes ☐No
44. Liver disease ☐Yes ☐No
45. Kidney disease/dialysis ☐Yes ☐No
46. Stomach trouble/ulcer ☐Yes ☐No
47. Sexually transmitted disease ☐Yes ☐No

Medication Allergies and other allergies

48. Penicillin or other antibiotics ☐Yes ☐No
49. Sulfa drugs ☐Yes ☐No
50. Dental anesthetics ☐Yes ☐No
51. Aspirin ☐Yes ☐No
52. Codeine/narcotics ☐Yes ☐No
53. Iodine ☐Yes ☐No
54. Latex products ☐Yes ☐No
55. Metal/nickels/jewelry ☐Yes ☐No
56. Other: ☐Yes ☐No

_____

Females Only

57. Are you pregnant? ☐Yes ☐No
58. Are you nursing now? ☐Yes ☐No
59. Do you take birth control pills? ☐Yes ☐No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐Yes ☐No
If so, please list them: _____

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐Yes ☐No

Social

62. Do you use tobacco? ☐Yes ☐No
63. Do you use alcohol? ☐Yes ☐No
64. Do you use recreational drug? ☐Yes ☐No

65. Do you have any other medical conditions not already listed above? ☐Yes ☐No
Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

Signature of PATIENT or Guardian: _____ Date: _____

Signature of DENTIST: _____ Date:_____