HEALTH HISTORY

Revised 11/15

Name ____ Date _____________________________

Date of last health care exam: ________________ Reason: ___________________________________
Hospitalized in the last 5 years? No/Yes Reason: ___________________________________

Are you currently receiving care? No/Yes Reason : ___________________________________

List the names of all physicians you are currently seeing:
1. _______________________________ 2. ________________________________

Please circle

Heart (Surgery, Disease, Attack)	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Blood Thinner Medications	No	Yes	Cancer	No	Yes
High Blood Pressure	No	Yes	Slow-Healing Mouth Sores	No	Yes
Stroke	No	Yes	Stomach Ulcers	No	Yes
HIV or AIDS	No	Yes	Kidney Disease	No	Yes
Asthma	No	Yes	Diabetes	No	Yes
Emphysema	No	Yes	Epilepsy	No	Yes
Hepatitis, Any Form	No	Yes	Glaucoma	No	Yes
Liver Disease (including Jaundice)	No	Yes	Mental Disorders	No	Yes
Latex Sensitivity	No	Yes	Are you pregnant?	No	Yes

Do you take Antibiotic Premedication before dental treatment? No/Yes

Circle all allergies:
a. Penicillin
b. Codeine
c. Other – Please List: ____

Tobacco Use: Smoke? No/Yes # packs/day? _________________
Chew? No/Yes

Are you concerned with bad breath? No/Yes

Do you wear CPAP? No/Yes Do you snore? No/Yes

Please list any medications you are currently taking:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Have you ever taken bone building drugs (Fosamax, Boniva, or Actonel) No/Yes If yes, when? ________

Do you take antacids? No/Yes
Do you take herbal supplements? No/Yes If yes, list _____________________________

For New Patients only: Previous Dentist's Name: ____
Date of Last Dental Visit: ____________________________
Have you ever had Periodontal (Gum) surgery? No/Yes If yes, when? ___________________________

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider.

______________________________ ______________________________ ____________________
Patient (Print Name) *Signature* *Date*

***To be completed by new patients. Current patients update every two years.**