

## Health History

Your name \_\_\_\_\_ Today's date \_\_\_\_\_

Physician name and phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Has there been any change(s) in your general health within the past 2 years?  Yes  No

Have you been hospitalized in the last 5 years?  Yes  No

Have you ever taken a medication for bone density? (e.g. Fosamax, Boniva, Prolia, Actonel, or Reclast)  Yes  No

Have you ever premedicated with antibiotics before dental appointments?  Yes  No

For Women: Are you Pregnant?  Yes  No Are you Nursing?  Yes  No

List all medications or supplements \_\_\_\_\_  
that you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking aspirin daily?  Yes  No How many mg? \_\_\_\_\_

List all medications that you are allergic to: \_\_\_\_\_

Check if you currently  Smoke  Vape If yes, how much per day? \_\_\_\_\_ Year Quit? \_\_\_\_\_

Check any of the following that you have had or are currently being treated for:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcohol Use            | <input type="checkbox"/> Epilepsy or Seizures  | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Nervous/Anxious       |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Psychiatric Care      |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Radiation Therapy     |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Surgery         | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Hepatitis Type _____  | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Steroid Treatment     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stomach Problems      |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Swelling of Ankles    |
| <input type="checkbox"/> Diabetes A1C _____     | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Diet Pills (fen-phen)  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Ulcer                 |
| <input type="checkbox"/> Dry Mouth              | <input type="checkbox"/> Lung Problems         | <input type="checkbox"/> Weight Loss           |
| <input type="checkbox"/> Other _____            |  |  |

Check any of the following that you have had or having problems with:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding/Clenching Teeth | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Deep Scalings | <input type="checkbox"/> Gum Surgery              | <input type="checkbox"/> Sores/Lumps in Mouth    |
| <input type="checkbox"/> Dental Pain   | <input type="checkbox"/> Sensitivity to Hot/Cold  | <input type="checkbox"/> Tender Jaw Joint        |
| <input type="checkbox"/> Other _____   |   |  |

Is there anything else we should know about your medical or dental history? \_\_\_\_\_

\_\_\_\_\_