

# Health History Form

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

***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:      Excellent      Good      Fair      Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_

Have there been any changes in your general health in the past year?      Yes      No

If yes, please describe: \_\_\_\_\_

Are you now under a doctor's care for a particular problem at this time?      Yes      No

If yes, why? \_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been hospitalized or had a serious illness?      Yes      No

If yes, why? \_\_\_\_\_

Have you ever had surgery?      Yes      No

If yes, when and what for? Date of surgery: \_\_\_\_\_ Reason for surgery: \_\_\_\_\_

Date of surgery: \_\_\_\_\_ Reason for surgery: \_\_\_\_\_

## PATIENT MEDICAL HISTORY

### Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
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Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
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Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
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Thyroid disease?	Yes	No	Arthritis?	Yes	No
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Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
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Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
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Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
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Glaucoma?	Yes	No	Sleep apnea?	Yes	No
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Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
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Any cancer, radiation, or chemotherapy?      Yes      No

Describe: \_\_\_\_\_ Date of your last treatment? \_\_\_\_\_

Do you have any other disease, condition or problem not listed above that you think the doctor should know about?      Yes      No

If yes, please explain: \_\_\_\_\_

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## FAMILY MEDICAL HISTORY

**Do you have a family history of any of the following? If yes, indicate the relationship.**

Diabetes? Yes No Relationship \_\_\_\_\_ Cancer? Yes No Relationship \_\_\_\_\_  
Heart disease? Yes No Relationship \_\_\_\_\_ Bleeding problems? Yes No Relationship \_\_\_\_\_  
Tumors? Yes No Relationship \_\_\_\_\_ Lung disease? Yes No Relationship \_\_\_\_\_  
Sleep Apnea? Yes No Relationship \_\_\_\_\_

## FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

## MEDICATIONS

**Are you using any of the following:**

Antibiotics? Yes No Prescription pain medication? Yes No  
Anticoagulants (blood thinners)? Yes No Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No  
Heart medications? Yes No Insulin or oral anti-diabetic drugs? Yes No  
Steroids (cortisone, prednisone, etc.)? Yes No Blood pressure medications? Yes No  
Antianxiety agents, antidepressants or other psychiatric medications? Yes No Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. Yes No

\_\_\_\_\_  
\_\_\_\_\_

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

## ALLERGIES

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

Latex? Yes No Codeine or other pain killers? Yes No  
Food products? Yes No Aspirin, Motrin, Aleve, or ibuprofen? Yes No  
Sedatives, barbiturates? Yes No Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_ Relationship? \_\_\_\_\_

Other drug or food allergies not listed above: \_\_\_\_\_

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## SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? \_\_\_\_\_

**Have you ever sought professional care or been hospitalized for:**

Substance abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

**Do you use:**

Alcohol? Yes No How often? \_\_\_\_\_

Marijuana? Yes No How often? \_\_\_\_\_

Recreational drugs? Yes No How often? \_\_\_\_\_

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## DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? \_\_\_\_\_

Do you wish to talk to the doctor privately about anything? Yes No

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**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

\_\_\_\_\_  
Printed name of patient, parent, guardian/Relationship

\_\_\_\_\_  
Doctor's Signature

## HEALTH HISTORY UPDATE

Date Comments Doctor's Signature

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