**Health History**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you in good health? YES NO 2. Any change in your health in the past year? YES NO

3. My Medical Doctor is (NAME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you had any serious illness or operation? YES NO Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5. Have you had any abnormal bleeding with tooth extraction or other surgery? YES NO

6. Do you bruise easily? YES NO 7. Have you ever had a transfusion? YES NO

8**. MEDICINES YOU ARE TAKING:** 9. **Are you ALLERGIC to any of the following?**

Antibiotics YES NO Local anesthetics or numbing YES NO

Coumadin or other blood thinners YES NO Penicillin or other antibiotic YES NO

Blood pressure medication YES NO Sulfa drugs YES NO

Digitalis or other heart drugs YES NO Barbiturates or sleeping pills YES NO

Nitroglycerine YES NO Aspirin YES NO

Antihistamines YES NO Iodine YES NO

Insulin or other med for diabetes YES NO Codeine or other narcotic YES NO

Cortisone or steroids YES NO Latex gloves YES NO

Oral contraceptives YES NO Sedatives YES NO

Herbal Supplements YES NO \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Vitamins YES NO

Bisphosphonate drugs (Fosamax, Boniva, Aredia, Actonel, Zometa) used in cancer and osteoporosis treatment YES NO

10. Please list drugs you are **ALLERGIC** to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Are you taking any medicines regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Do you now have or have you had in the past any of the following diseases or problems?

\_\_\_Sleep Apnea \_\_\_Diabetes

\_\_\_AIDS \_\_\_Frequent thirst

\_\_\_Hives or rash \_\_\_Implants or replacements?

\_\_\_Asthma \_\_\_Breast

\_\_\_ HIV positive \_\_\_Joint (knee or hip)

\_\_\_COPD \_\_\_Dental

\_\_\_Syphilis \_\_\_Chin

\_\_\_Herpes \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other sexually transmitted diseases \_\_\_Smoke cigarettes

\_\_\_GERD (Reflux Disease) \_\_\_Swollen lymph nodes

\_\_\_High blood pressure \_\_\_Thrush

\_\_\_Heart attack \_\_\_Yeast infections

\_\_\_Stroke \_\_\_Cold sores/fever blisters

\_\_\_Chest pain on exertion \_\_\_Dry mouth

\_\_\_Shortness of breath \_\_\_Shingles

\_\_\_Swollen ankles \_\_\_Hepatitis

\_\_\_Excessive bleeding \_\_\_Cancer

\_\_\_Damaged heart valves \_\_\_Osteoporosis

\_\_\_Rheumatic fever \_\_\_Diarrhea

\_\_\_Pacemaker \_\_\_Epilepsy

\_\_\_Thyroid problems \_\_\_Kidney problems

\_\_\_Seizures \_\_\_Tuberculosis

**\_\_\_**Snoring

**WOMEN**

**OTHER** \_\_\_Pregnant at this time

Anything else we should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Nursing at this time

\_\_\_Menstrual problems

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Menopause

**I have read all the information on this sheet and have completed the answers. I affirm that this information is correct to the best of my knowledge and that I will inform my dentist of any changes in my health history and medicines prescribed to me.**

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**Signature**  **Date**