Health History

Patient Name: _____

D.O.B: _____

Please check all that apply (current or past)

1._____heart condition or heart surgery

2._____high blood pressure

3._____regular use of aspirin or arthritis medication

4._____endocarditis

5._____ liver disease

6._____ Hepatitis A___B _ C____

7._____ bleeding disorder

8._____anemia

9._____bisphosphonate use (bone density medications such as Fosamax, Actonel, Boniva)

10._____history of TMJ disorder

11._____history of clenching or grinding teeth

12._____GI disorders

13._____ ulcers

14._____ Diabetes Type:_____Recent A1C measurement:_____ Glucose:_____

15._____kidney disease

16._____tuberculosis

17._____asthma

18._____COPD if yes, on oxygen_____liters per minute

19._____thyroid/hormonal condition

20._____ seizures

21._____ neurological condition

22._____cancer or malignancy

23._____psychiatric condition

24._____HIV positive if yes, latest CD4 count_____

25._____immune-compromising disease

26._____ joint replacement

27._____ premedication for dental appointments

28._____chronic sinus condition

29._____ currently pregnant if yes, month:_____

30._____ active smoker

Please provide brief details for any items checked above

Item #

Please provide a list of all current prescription, over-the-counter, vitamin and supplemental medications:

Drug:	Condition being treated:

Allergy or intolerance to medications or materials (i.e. latex, penicillin, etc):

Drug/Material:	Reaction:

Medical doctor(s) name(s) and specialty:

Please provide further details for any other medical condition not previously noted:

To the best of my knowledge, all the preceding answers and information are correct and complete. I will update my records at my next appointment if any changes occur. I have reviewed and verified all information.

_____ _____

Patient Signature **Date**

_____ _____

Doctors Signature **Date**