# HEALTH HISTORY FORM

Patient Name _____Preferred Name _____Date of Birth_____

Name of Primary Care Physician_____ PCP Phone Number (_____)_____

Most Recent Physical Exam_____ Purpose_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury_____ | ☐ | ☐ |
| 2. an ALLERGIC reaction to: | | |
| ☐ Local anesthetics ☐ Aspirin | | |
| ☐ Penicillin ☐ Erythromycin | | |
| ☐ Sulfa Drugs ☐ Codeine/other narcotics | | |
| ☐ Metals ☐ Latex | | |
| ☐ Tetracycline ☐ Other: _____ | | |
| 3. heart problems, or cardiac stent in last 6 months_____ | ☐ | ☐ |
| 4. history of infective endocarditis_____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO)_____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator_____ | ☐ | ☐ |
| 7. congenital heart defect_____ | ☐ | ☐ |
| 8. artificial joint (date_____)_____ | ☐ | ☐ |
| 9. high blood pressure_____ | ☐ | ☐ |
| 10. low blood pressure_____ | ☐ | ☐ |
| 11. stroke_____ | ☐ | ☐ |
| 12. anemia or other blood disorder_____ | ☐ | ☐ |
| 13. abnormal bleeding_____ | ☐ | ☐ |
| 14. hemophilia_____ | ☐ | ☐ |
| 15. rheumatic or scarlet fever_____ | ☐ | ☐ |
| 16. emphysema/ sarcoidosis_____ | ☐ | ☐ |
| 17. tuberculosis_____ | ☐ | ☐ |
| 18. sleep problems or snore_____ | ☐ | ☐ |
| 19. asthma/breathing problems_____ | ☐ | ☐ |
| 20. kidney disease_____ | ☐ | ☐ |
| 21. thyroid, parathyroid disease, or calcium deficiency___ | ☐ | ☐ |
| 22. liver disease_____ | ☐ | ☐ |
| 23. jaundice_____ | ☐ | ☐ |
| 24. hormone deficiency_____ | ☐ | ☐ |
| 25. sinus trouble_____ | ☐ | ☐ |
| 26. stomach or duodenal ulcer_____ | ☐ | ☐ |
| 27. digestive disorders (gastric reflux)_____ | ☐ | ☐ |
| 28. osteoporosis/osteopenia (taking bisphosphonates)___ | ☐ | ☐ |
| 29. arthritis_____ | ☐ | ☐ |
| 30. glaucoma_____ | ☐ | ☐ |
| 31. contact lenses_____ | ☐ | ☐ |
| 32. head or neck injuries_____ | ☐ | ☐ |
| 33. epilepsy, convulsion, seizures_____ | ☐ | ☐ |
| 34. neurological problems (if yes, type_____)_ | ☐ | ☐ |
| 35. herpes, viral infections, or cold sores_____ | ☐ | ☐ |
| 36. lumps or swelling around the mouth_____ | ☐ | ☐ |
| 37. High cholesterol or taking statin drugs_____ | ☐ | ☐ |
| 38. STI/STD_____ | ☐ | ☐ |
| 39. hepatitis (if yes, type_____)_____ | ☐ | ☐ |
| 40. HIV/AIDS_____ | ☐ | ☐ |
| 41. tumor, abnormal growth_____ | ☐ | ☐ |
| 42. cancer, chemotherapy, radiation therapy_____ | ☐ | ☐ |
| 43. mental health disorder(s)_____ | ☐ | ☐ |
| 44. excessive urination_____ | ☐ | ☐ |
| 45. diabetes (if yes, type I or II)_____ | ☐ | ☐ |
| 46. frequent headaches or migraines_____ | ☐ | ☐ |
| ARE YOU: | | |
| 48. presently being treated for any other illness_____ | ☐ | ☐ |
| 49. aware of a change in your health (fever, new cough)_ | ☐ | ☐ |
| 50. taking weight management medications (fen-phen)___ | ☐ | ☐ |
| 51. taking dietary supplements_____ | ☐ | ☐ |
| 52. often exhausted or fatigued_____ | ☐ | ☐ |
| 55. FEMALE - are you breast feeding_____ | ☐ | ☐ |
| 56. FEMALE - taking birth control_____ | ☐ | ☐ |
| 57. FEMALE - pregnant_____ | ☐ | ☐ |
| 58. MALE - prostate disorders_____ | ☐ | ☐ |
| DO YOU: | | |
| 47. use alcohol (per week_____)_____ | ☐ | ☐ |
| 54. use tobacco (smoke, vape, snuff, or chew)_____ | ☐ | ☐ |

Describe any current medical condition or treatment that may possibly affect your dental treatment (i.e. botox, collagen injections) : _____

_____

**List all medications, supplements, and or vitamins taken within the last 2 years**

| DRUG/DOSAGE | PURPOSE/DATE OF LAST DOSE | DRUG/DOSAGE | PURPOSE/DATE OF LAST DOSE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS.**

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____