Heath History

Patient name_____, DOB_____

Y N Do you have a dental condition that causes pain or discomfort? Explain: _____

Y N Have you had problems with prior dental treatment? Explain: _____

Y N Has there been a change in your health within the last year? Explain:_____

Y N Have you had a serious illness or been hospitalized within the last 2 years? Explain: _____

Y N Allergies/sensitivity to medications, local anesthetics, metals or latex? Specify: _____

Y N Are you pregnant or nursing? Due date_____

Y N History of Bisphosphonate use (example Fosamax, Xgeva, Aredia, Boniva, Didronel, Fosamax, Reclast, Xgeva and Zometa)? Specify: _____

Y N Any Heart Conditions (example Heart attack, heart murmur, prosthetic heart valve)? Specify: _____

Y N Lung Conditions/Respiratory Problems (example Asthma, COPD)? Specify: _____

Y N Kidney Disease or Liver Disease (eg. Hepatitis, Cirrhosis)? Specify _____

Y N Diabetes? Insulin dependant? Y / N

Y N Bleeding Problems (eg. Anemia, Hemophilia)? Specify: _____

Y N Fainting spells or seizures? Specify: _____

Y N Tumors/Cancer? Location, date of diagnosis? _____

Y N Radiation Treatment? Site? _____

Y N Chemotherapy? End date? _____

Y N HIV or AIDS? Viral Load: _____

Y N Artificial Joint? Type of joint (eg. shoulder, knee, hip) /date of surgery: _____

Y N Neurologic Disorders (eg. Fibromyalgia)? Explain: _____

Y N Sinus Problems?

Y N Headaches (monthly or more)? How often? _____

Y N Syphilis, Gonorrhea, Herpes? Specify: _____

Y N Tobacco in any form? How often, for how many years? : _____

Y N Alcohol? How often, for how many years? _____

a. Have you ever been diagnosed with Alcoholism? Y / N

Y N Do you use recreational Drugs? Type? _____

Y N Psychiatric Care? Diagnosis? (eg. Bipolar, Depression, Schizophrenia) _____

Medication List:

_____

_____

_____

Is there additional information about your general health we should know?

_____

Signature _____ Date _____