PATIENT HEALTH HISTORY

Patient Name: _____

Patient Date of Birth: _____

Are you currently under the care of a physician? YES NO Last physical exam: _____

Physician Name: _____ Physician Phone: _____

Do you normally pre-medicate (take antibiotics) prior to having dental treatment or dental cleanings? _____

GENERAL CONDITIONS:

Y N Present/past tobacco use (smoke or chew)
How much? _____
Y N Present/past alcohol use
How much? _____
Y N Present/past recreational drug use

EYES:

Y N Glaucoma
Y N Other/surgery _____

EARS:

Y N Pain/discomfort around ears

RESPIRATORY:

Y N Tuberculosis
Y N Emphysema
Y N Asthma/hay fever
Y N Other _____

FEMALE:

Y N Pregnant; # months _____
Due date _____
Y N Breast-feeding
Y N Birth control pills

ENDOCRINE:

Y N Diabetes
Y N Thyroid condition
Y N Hormone imbalance

NERVOUS SYSTEM:

Y N Stroke
Y N Epilepsy/seizures
Y N Head or neck injures
Y N Dizziness/fainting

BONES, MUSCLES:

Y N Arthritis/Rheumatism
Y N Artificial joints/limbs
Y N Osteoporosis

DIGESTIVE:

Y N Hepatitis (Type _____)
Y N Ulcers
Y N Colitis
Y N Gastric Reflux (GERD)
Y N Other _____

HEART, BLOOD VESSELS:

Y N Heart problems/trouble
Y N Chest pain/discomfort
Y N Heart murmur

HEART, BLOOD VESSELS: continued

Y N Mitral valve prolapse
Y N Congenital heart defect
Y N Pacemaker
Y N Artificial heart valve
Y N High blood pressure
Y N Low blood pressure
Y N Heart surgery
Y N High cholesterol
Y N Other _____

URINARY:

Y N Kidney disease
Y N Increased frequency of urination

BLOOD:

Y N Anemia or other blood disorders
Y N Do you take a Blood Thinner

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:

Y N Bisphosphonates
Y N Actonel
Y N Boniva
Y N Fosamax
Y N Reclast
Y N Zometa

OTHER:

Y N Cancer
Y N Radiation/chemotherapy
Y N HIV/Aids
Y N Psychiatric treatment

ALLERGIES, REACTIONS:

Y N Dental asesthesia
Y N Penicillin/other _____
Y N Sulfa drugs
Y N Aspirin/Codeine
Y N Barbiturates/sedatives
Y N Latex
Y N Other _____

SLEEP MEDICINE:

Y N Snore or Gasp?
Y N Tired during the day?
Y N Ever had sleep test?
When _____ Where _____
Y N Diagnosed Sleep Apnea
Y N Wear CPAP?
Y N Clench or grind teeth?
Y N Headaches or sore jaw?

MEDICATIONS:

Please list names of current medication(s)

_____

The above information is true to the best of my knowledge. Should further information be needed you have my permission to ask the respective healthcare provider, who may release such information to you. I will inform you of any changes in my health or medications.

Signature: _____ Reviewed by: _____ Date: _____