

## MEDICAL HEALTH HISTORY

PATIENT'S NAME: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PLEASE LIST NAME AND DOSAGE OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING HERBAL REMEDIES, AND OVER THE COUNTER MEDICATIONS:

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HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST 5 YEARS? IF SO, WHY?

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HAVE YOU HAD ANY MEDICAL CARE WITHIN THE PAST TWO YEARS? IF SO, FOR WHAT?

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DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? PLEASE MARK THE CORRESPONDING ANSWER TO ALL QUESTIONS. THANK YOU.

<b>HEART PROBLEMS</b>	<b>YES</b>	<b>NO</b>	<b>BLOOD PROBLEMS</b>	<b>YES</b>	<b>NO</b>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease (Anemia)	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>			
Heart valve issues	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGY PROBLEMS</b>	<b>YES</b>	<b>NO</b>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medications	<input type="checkbox"/>	<input type="checkbox"/>	Taking allergy medications	<input type="checkbox"/>	<input type="checkbox"/>
			Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTESTINAL PROBLEMS</b>	<b>YES</b>	<b>NO</b>	OTHER: _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Weight Gain or Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Special diet	<input type="checkbox"/>	<input type="checkbox"/>	_____		
IBS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<b>DIABETES</b>	<b>YES</b>	<b>NO</b>	<b>BONE OR JOINT PROBLEMS</b>	<b>YES</b>	<b>NO</b>
Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry often	<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU ALLERGIC, OR HAVE YOU REACTED ADVERSELY, TO ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Local anesthetics (Novocain)	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Codeine, Demerol or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____		
Aspirin, Acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	_____		

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants (ie: Coumadin or warfin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medications	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Orinase, or similar drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone or other steroids	<input type="checkbox"/>	<input type="checkbox"/>	Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drugs/supplements	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Fainting spells, seizures or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke(s)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A _____ B _____ C _____	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STD	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	HIV-positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or other respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or tumors	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a C-PAP machine	<input type="checkbox"/>	<input type="checkbox"/>	Implants	<input type="checkbox"/>	<input type="checkbox"/>

Within the past 15 years have you received IV Chemotherapy?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

What is the name and phone number of your Oncologist: \_\_\_\_\_

Within the last 10 years, have you been prescribed Fosamax, Actonel, Didronel, or Bonivia?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

(oral bisphosphonates used to treat osteoporosis)

	YES	NO		YES	NO
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If so how much? _____			If so, what and how often? _____		

Do you smoke or use smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If so, how often? _____			_____
How long have you used tobacco? _____			

	YES	NO
Do you have a history of alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken prescription medications for weight loss (diet pills)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did you take Fen-Phen _____ PONDIMEN _____ Redux _____ Other _____		
If yes to the above, have you had a medical exam for heart issues?	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN:

	YES	NO		YES	NO
Are you taking contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any menopausal symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or think you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____					
Have you had breast augmentation?	<input type="checkbox"/>	<input type="checkbox"/>			
If so, date of surgery: _____					

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH WE SHOULD KNOW?

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I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL THE QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THIS OFFICE OF ANY CHANGE IN MY HEALTH OR MEDICATIONS.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**OFFICE USE ONLY:**

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