PATIENT HEALTH HISTORY

PRIMARY CARE PHYSICIAN	PHYSICIAN'S ADDRESS	CITY	PHONE

DATE OF LAST PHYSICAL	PURPOSE	BLOOD PRESSURE

1. WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH? ☐ GOOD ☐ FAIR ☐ POOR

	YES	NO
2. HAVE YOU EVER BEEN HOSPITALIZED, OR HAD ANY SERIOUS OR CHRONIC ILLNESS?	☐	☐
IF YES, PLEASE LIST _____		
3. ARE YOU TAKING ANY MEDICATION (INCLUDING HERBALS OR OVER-THE-COUNTER MEDS, E.G. ASPIRIN)	☐	☐
IF YES, PLEASE LIST _____		
4. HAVE YOU EVER TAKEN PRESCRIPTION WEIGHT LOSS MEDICATIONS INCLUDING FEN-PHEN, PONDIMEN, OR REDUX?	☐	☐
5. DO YOU USE ANY RECREATIONAL/"STREET" DRUGS, INCLUDING COCAINE?	☐	☐
6. HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR CHEMICAL DEPENDENCY/ALCOHOLISM?	☐	☐

7. ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING? **IF NONE, CHECK HERE** ☐

☐ ASPIRIN	☐ PENICILLIN	☐ LOCAL ANESTHETIC ("NOVOCAINE")
☐ CODEINE	☐ ERYTHROMYCIN	☐ FLUORIDE
☐ IBUPROFEN	☐ TETRACYCLINE	☐ ANY METAL (E.G. GOLD, NICKEL)
☐ NITROUS OXIDE	☐ ANY OTHER ANTIBIOTIC	☐ LATEX, TALC, OR CORNSTARCH

☐ ANY OTHER MEDICATION OR SUBSTANCE _____

8. HAVE YOU EVER HAD ANY OF THE FOLLOWING? **IF NONE, CHECK HERE** ☐

☐ HEART TROUBLE	☐ KIDNEY PROBLEM/DISEASE	☐ DIABETES
☐ HEART ATTACK	☐ HEPATITIS--TYPE_____	☐ THYROID PROBLEMS/DISEASE
☐ MITRAL VALVE PROLAPSE	☐ TUBERCULOSIS OR POSITIVE PATCH TEST	☐ ARTHRITIS
☐ HEART MURMUR	☐ AIDS/HIV	☐ STOMACH ULCERS/ HIATAL HERNIA
☐ HIGH BLOOD PRESSURE	☐ SEXUALLY-TRANSMITTED DISEASE	☐ ASTHMA
☐ TUMOR OR GROWTH	☐ PROLONGED BLEEDING FROM CUT OR	☐ EPILEPSY
☐ RADIATION OR CHEMOTHERAPY	TOOTH EXTRACTION	☐ HIP, KNEE (OR OTHER JOINT) REPLACEMENT
☐ PERSISTENT COUGH	☐ WEIGHT LOSS/GAIN OF 10 LBS OR MORE IN THE PAST YEAR	

9. DOES ANYONE IN YOUR FAMILY HAVE DIABETES? ☐ YES ☐ NO	ARE YOU FREQUENTLY THIRSTY?	☐ ☐
10. DO YOU SMOKE/USE TOBACCO? ☐ YES ☐ NO HOW MUCH? _____	HAVE YOU TRIED TO QUIT?	☐ ☐
11. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE YOU THINK WE SHOULD KNOW ABOUT?		☐ ☐
IF YES, EXPLAIN _____		
12. ARE YOU TAKING NOW OR EVER TAKEN FOSAMAX, BONIVA, ACTONEL, DIDRONEL, ZOMETA, AREDIA OR OTHER "BONE BUILDING" DRUGS? WHICH ONE _____? FOR HOW LONG_____?		☐ ☐
13. DO YOU HAVE A HISTORY OF BULIMIA OR ANOREXIA?		☐ ☐
FOR WOMEN ONLY:		
ARE YOU NOW OR DO YOU EXPECT TO BE PREGNANT DURING THE COURSE OF DENTAL CARE?		☐ ☐
ARE YOU NOW TAKING OR DO YOU EXPECT TO BE TAKING BIRTH CONTROL PILLS?		☐ ☐

YOUR SIGNATURE _____ **DATE** _____

RELATIONSHIP TO PATIENT _____ **(I.E.SELF, PARENT, GUARDIAN)**

PERSON TO CONTACT FOR EMERGENCY--NOT LIVING WITH YOU _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

HEALTH HISTORY UPDATES - for office use only

DATE _____ INITIALS _____	DATE _____ INITIALS _____	DATE _____ INITIALS _____
CHANGES _____	CHANGES _____	CHANGES _____
DATE _____ INITIALS _____	DATE _____ INITIALS _____	DATE _____ INITIALS _____
CHANGES _____	CHANGES _____	CHANGES _____