HEALTH HISTORY

Patient's Name **Date of Birth** **Date**

Y N Are you in good health? ____________________

Y N Have there been any change in your health in the past year? ___________________________________

Date of last physical exam: __________________

Y N Are you under a physician's care for a particular problem? _________________________________

____

DO YOU HAVE OR HAVE YOU EVER HAD:

Y N Cardiovascular Disease (i.e. Heart Disease, High Blood Pressure, High Cholesterol: _________________________

Y N Lung Disease (i.e. Emphysema, COPD)? __________

Y N Breathing problems (i.e. Asthma, Sleep Apnea)? ____

Y N Seizures? __________________________________

Y N Bleeding Disorder? __________________________

Y N Liver Disease (i.e. Jaundice, Hepatitis)? ___________

Y N Kidney Disease? _____________________________

Y N Diabetes?__________________________________

Y N Thyroid Disease (i.e. Goiter)? ___________________

Y N Arthritis? __________________________________

Y N Stomach Ulcers or Colitis? ______________________

Y N Glaucoma? _________________________________

Y N Osteoporosis? _______________________________

Y N Implants placed anywhere in your body? ___________

Y N Radiation or Chemotherapy treatment for cancer?____

Y N TMJ (jaw joint) problems (grind or clench teeth)? ____

Y N Sinus or Nasal problems? ______________________

Y N Any disease or drug that depressed your immune system? ____

Y N Any psychiatric or emotional disorders? ___________

Y N Any other medical conditions? ___________________

Height _____________ **Weight** _________________

Y N Have you ever had any surgery?

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PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

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Y N Any Allergies or Adverse reactions to medications or foods? ____

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Y N Do you smoke or chew Tobacco?
How much per day? ________

Y N Is there any past or present history of alcohol or drug dependency? _____________________________________

Y N Have you had any serious problems associated with any previous medical, surgical, dental or anesthetic treatment?
____

Y N Do you have any other disease, condition or problem not listed above? _____________________________________
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Y N Do you wish to disclose any other information related to your health or your visit today?_______________________
____

FOR WOMEN ONLY:

Y N Are you Pregnant, or is there any chance you might be Pregnant?

Y N Are you nursing?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Notes (office use only):

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

Date Signature of Patient (or legal guardian) Doctor's Initials

Medical History Update:

Please add any new medical conditions, surgeries, medications, allergies or hospitalizations since you last completed the Medical History Form.

Update 1:
Date:____________

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Update 2:
Date:____________

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Update 3:

Date: ___________

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Update 4:

Date:___________

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Update :

Date:___________

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