PATIENT HEALTH HISTORY **Today's Date: _____________**

Patient Name: ______________________________ Date of Birth: __________________ Age: __________

Are you under the care of a physician for a specific condition? ☐ **YES** ☐ **NO**

If yes, physician's name: ____

Have you been hospitalized in the last 5 years for any condition? ☐ **YES** ☐ **NO**

If yes, please explain: ____

Do you require pre-medication for dental treatment? ☐ **YES** ☐ **NO**

If yes, what is the name of the medication? ____

Do you use any form of tobacco? ☐ **YES** ☐ **NO**

Do you use any recreational drugs? ☐ **YES** ☐ **NO**

Have you ever taken a class of drugs called a bisphosphonate, often used in treatment of osteoporosis or cancer therapy? (Examples: Fosamax, Boniva, Actonel, Recalst, Aredia) ☐ **YES** ☐ **NO**

Do you have or have you had any of the following?

Heart Disorders

- Heart disease/failure ☐ **Y** ☐ **N**
- Heart attack ☐ **Y** ☐ **N**
- Heart murmur ☐ **Y** ☐ **N**
- Heart arrhythmias ☐ **Y** ☐ **N**
- Mitral valve prolapse ☐ **Y** ☐ **N**
- High blood pressure ☐ **Y** ☐ **N**
- Rheumatic fever ☐ **Y** ☐ **N**
- Heart surgeries, like
  - Bypass ☐ **Y** ☐ **N**
  - Pacemaker ☐ **Y** ☐ **N**
  - Valve replacement ☐ **Y** ☐ **N**
  - Stent ☐ **Y** ☐ **N**

Blood Disorders

- Hemophelia ☐ **Y** ☐ **N**
- Anemia ☐ **Y** ☐ **N**
- Taking a blood thinner ☐ **Y** ☐ **N**

Neurologic Disorders

- Stroke ☐ **Y** ☐ **N**
- Epilepsy/Seizures ☐ **Y** ☐ **N**
- ADHD/ADD ☐ **Y** ☐ **N**
- Anxiety/Depression ☐ **Y** ☐ **N**
- Autism ☐ **Y** ☐ **N**

Gastrointestinal Disorders

- Crohn's Disease ☐ **Y** ☐ **N**
- Gastritis/Colitis ☐ **Y** ☐ **N**
- Hepatitis or Liver disease ☐ **Y** ☐ **N**
- Jaundice ☐ **Y** ☐ **N**

Respiratory Disorders

- Asthma ☐ **Y** ☐ **N**
- Emphysema/COPD ☐ **Y** ☐ **N**
- Tuberculosis ☐ **Y** ☐ **N**

Musculoskeletal Disorders

- Arthritis ☐ **Y** ☐ **N**
- Osteoporosis or Osteopetrosis ☐ **Y** ☐ **N**
- Prosthetic Joint Replacement ☐ **Y** ☐ **N**
  - Which joint and date? _______________

Endocrine Disorders

- Diabetes I or II ☐ **Y** ☐ **N**
- Thyroid Disease ☐ **Y** ☐ **N**

Genitourinary Tract Disorders

- Kidney Disease ☐ **Y** ☐ **N**
- Venereal Disease/STD ☐ **Y** ☐ **N**
- AIDS/HIV ☐ **Y** ☐ **N**
- HPV ☐ **Y** ☐ **N**

Cancer therapy

- Cancer ☐ **Y** ☐ **N**
  - What type and date? _______________
- Bisphosphonate therapy ☐ **Y** ☐ **N**
- Radiation therapy ☐ **Y** ☐ **N**
- Chemotherapy ☐ **Y** ☐ **N**

Do you have any allergies to the following?

Latex	☐ **Y**	☐ **N**	Acrylic Materials	☐ **Y**	☐ **N**
Penicillin	☐ **Y**	☐ **N**	Any Metals	☐ **Y**	☐ **N**
Codeine	☐ **Y**	☐ **N**	Sulfa drugs	☐ **Y**	☐ **N**
Aspirin	☐ **Y**	☐ **N**	Any other drugs	☐ **Y**	☐ **N**
Anesthetics	☐ **Y**	☐ **N**			

For women only: Please check all that apply.

☐ Pregnant ☐ Trying to get pregnant ☐ Taking an oral contraceptive ☐ Nursing

Do you have any other condition, disease, or problem that is not listed above?

____

Please list all the medications that you take and their dosage and frequency. (Please include over-the-counter medications, daily aspirin, and daily vitamins). **If you take none, please write none.**

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Please review that you have filled out the form in its entirety and that it is accurate to your knowledge.

Signature of patient or guardian: ____________________________________ Date: _______________