Health History

Patient's Name _____Birthdate _____

Physician's Name _____ Date of last physical examination? _____

Have you ever had, or do you presently have any of the following? (*Please check boxes that apply):*

☐ High Blood Pressure	☐ Heart Murmur
☐ Anemia	☐ Herpes
☐ Stroke	☐ AIDS/HIV Infection
☐ Asthma / Emphysema	☐ History of Infective Endocarditis
☐ Cardiac Pacemaker	☐ Heart Attack
☐ Cancer	☐ Kidney Disease
☐ Thyroid Disease	☐ Cardiac Transplant / Congenital Heart Defect
☐ Cardiovascular Disease	☐ Respiratory Problems / Shortness of Breath / COPD
☐ Glaucoma	☐ Bleeding Abnormally
☐ Epilepsy / Convulsions	☐ Chemotherapy and/or Radiation Treatment
☐ Diabetes	☐ TB (Tuberculosis)
☐ Frequent Chest Pains	☐ Sexually Transmitted Disease
☐ Joint Replacements / Implants	☐ **Women:** Pregnant or nursing
☐ Hepatitis, Jaundice, or Liver Disease	☐ Artificial Heart Valve
☐ Low Blood Pressure	☐ Leukemia
☐ Angina	☐ Migraines

Please list any disease, condition, or problem that your dentist should know about before proceeding with treatment:

_____

Have you ever taken "**Bisphosphonates**?" (Ex: Fosamax, Boniva, Actonel, Didronel, Aredia, Reclast, Zometa) _____

Infusion? Injection? Pill form?

Are you currently taking Blood Thinners? (Ex: Aspirin, Coumadin, Plavix, or Trental) _____

Have you ever used tobacco? _____ If so, how much and for how long? _____

Medications

List any medications you are currently taking:

_____
_____
_____
_____
_____

Allergies

Are you allergic or have reacted adversely to:

_____Local Anesthetic
_____Penicillin
_____Codeine
_____Iodine
_____Other _____

_____Aspirin
_____Sulfa Drugs
_____Barbiturates
_____Latex

I certify that to the best of my knowledge, the above information is complete and accurate.

_____ _____

Signature of Patient (or Legal Guardian) Date