

# Health History

Patients Name \_\_\_\_\_ Email Address: \_\_\_\_\_

**Doctor's Notes**

1. Are you under a physicians care? Y / N Since When? \_\_\_\_\_ Why? \_\_\_\_\_  
Physicians Name \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_
2. When was your last complete Physical Exam? \_\_\_\_\_
3. Are you taking any medications? If yes, please list \_\_\_\_\_ Y / N
4. Are you allergic to medications or substances? If yes, please list \_\_\_\_\_ Y / N
5. Do you have any other allergies? If so, please list \_\_\_\_\_ Y / N
6. Do you have any problems with penicillin, antibiotics, local anesthetics, or other medications?  
If so, please list \_\_\_\_\_ Y / N
7. Are you sensitive to any metals or latex? If so, please note \_\_\_\_\_ Y / N
8. Are you pregnant or suspect you may be?.....Y / N
9. Have you ever been treated for, or told you have heart disease? .....Y / N
10. Do you have a pacemaker or an artificial heart valve implant?.....Y / N
11. Have you ever had rheumatic fever?.....Y / N
12. Are you aware of any heart murmurs?.....Y / N
13. Do you have high or low blood pressure?.....High Low Normal
14. Have you ever had a serious illness or major surgery? If yes, please list \_\_\_\_\_ Y / N
15. Have you ever had radiation or chemotherapy for a tumor or other condition?.....Y / N
16. Do you have soreness, clicking or popping in your jaw joint?.....Y / N
17. Do you have any artificial joints, hips, or prosthesis?.....Y / N
18. Do you have any blood disorders, such as anemia, leukemia, hemophilia, etc?  
If so, please list \_\_\_\_\_ Y / N
19. Have you ever bled excessively after being cut or injured? .....Y / N
20. Do you have any kidney problems?.....Y / N
21. Are you diabetic? If yes, what type? \_\_\_\_\_ Y / N
22. Are you HIV positive?.....Y / N
23. Have you had or do you test positive for hepatitis? If yes, what type? \_\_\_\_\_ Y / N
24. Do you or have you had tuberculosis?.....Y / N
25. Do you smoke, chew, use snuff, or any other form of tobacco?.....Y / N
26. Do you habitually use controlled substances?.....Y / N
27. Have you ever been told to take antibiotics before any dental treatment?.....Y / N
28. Have you ever taken any of the following Bisphosphonates medication: fosomax (i.e.,alendronat), Actonel (i.e., risedronate), aredia( i.e., pamidronate), bonefos (i.e.,Clodronate), boniva(i.e.,ibandronate), didronel(i.e.,etidronate), ostac (i.e.,pamidronate), bonefos (i.e.,tiludronate), zometa (i.e.,zoledronic acid) etc.  
If yes, please specify \_\_\_\_\_ Y / N
29. Have you ever had cancer in the bone, or any other bone disease?  
If yes, please specify \_\_\_\_\_ Y / N
30. Is there anything else we should know about your health that was not covered on this form?  
If yes, please explain \_\_\_\_\_ Y / N
31. When was your last dental exam cleaning? \_\_\_\_\_

**\*I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation, and/or other medication necessary for dental treatment. The parent or guardian is required to remain in the dental office during their child's treatment.**

**Initial Visit Patient/Guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**First update** any changes \_\_\_\_\_

Patient/Guardian signature \_\_\_\_\_

**Second update** any changes \_\_\_\_\_

Patient/Guardian signature \_\_\_\_\_

**Third update** any changes \_\_\_\_\_

Patient/Guardian signature \_\_\_\_\_