PATIENT HEALTH HISTORY

GENERAL DENTIST'S NAME_____ City _____ State _____

MEDICAL DOCTOR'S NAME_____ City _____ State _____

1. Reason for this visit _____
2. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   If yes, please list: _____
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. List any drugs or medications you are currently taking or have taken in the past two years.
   _____
5. Are you currently taking, or, have you taken in the past Bisphosphonate (bone density) drugs? ..... YES NO
6. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? ..... YES NO
   If yes, please list: _____
7. Are you allergic to Latex? ..... YES NO
8. Circle any of the following conditions you presently have, or have had previously.

Heart Disease or Attack	Kidney Disease	AIDS / ARC / HIV Positive
Angina Pectoris	Kidney Dialysis	Hepatitus A (infectious)
High Blood Pressure	Emphysema	Hepatitus B (serum)
Heart Murmur	Tuberculosis (TB)	Liver Disease
Rheumatic Fever	Asthma	Yellow Jaundice
Congenital Heart Lesions	Hay Fever	Blood Transfusion
Mitral Valve Prolapse	Sinus Trouble	Drug Addiction
Infectious Endocarditis	Allergies or Hives	Hemophilia / Bleeding Disorder
Scarlet Fever	Diabetes	Venereal Disease
Artificial Heart Valve	Thyroid Disease	(Syphilis, Gonorrhea)
Heart Pacemaker	Radiation Therapy	Cold Sores / Fever Blisters
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Epilepsy or Seizures
Artificial Joints (Hip, Knee)	Arthritis	Fainting or Dizzy Spells
Anemia	Rheumatism	Psychiatric Treatment
Stroke	Cortisone Medication	Sickle Cell Disease
Glaucoma	Pain in Jaw Joints	Ulcers

9. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
10. Do your ankles swell during the day? ..... YES NO
11. Do you use more than 2 pillows to sleep? ..... YES NO
12. Do you ever wake up from sleep short of breath? ..... YES NO
13. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
14. Do you have any disease, condition, or problem not listed? _____
15. Have you ever had any allergic reactions of symptoms to local anesthetic (novocaine, xylocaine, etc.)? ..... YES NO
16. FOR WOMEN ONLY: Are you pregnant? ☐Yes ☐No If yes, what month?____ Are you taking birth control pills?____

Comments:_____

I agree that I have read the above material and the information provided by me is truthful and accurate to the best of my knowledge.

Patient Signature _____ **Today's Date** _____

Guardian Signature _____ **Today's Date** _____