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# HEALTH HISTORY

Patient Name ______________________ Birthdate ______________

Physician's Name ______________________ Physician's Phone ______________

Have you ever been advised to take prophylactic antibiotics before dental treatment? . . . . . . ❑ Yes ❑ No

If yes, please list reason(s) ______________________

Have you ever been advised not to take a particular medication? . . . . . . ❑ Yes ❑ No

If yes, please list ______________________

Do you take blood thinners? . . . . . . ❑ Yes ❑ No

Have you ever taken bone loss prevention drugs (bisphosphonates) for osteoporosis, metastatic cancer, or other conditions? Examples of bisphosphonates are alendronate (Fosamax), risedronate (Actonel), pamidronate (Aredia), Ibandronate (Boniva), and zoledronate (Zometa, Reclast) . . . . . . ❑ Yes ❑ No

**Are you allergic to any of the following?**

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Latex |
| ❑ | ❑ | Penicillin or any other antibiotic: If yes, please list ______ |
| ❑ | ❑ | Other allergies: If yes, please list ______ |

**Do you have, or have you ever had, any of the following?**

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Alcohol or Drug Addiction |
| ❑ | ❑ | Anaphylaxis |
| ❑ | ❑ | Artificial Joint Replacement (hip, knee, etc.) |
| ❑ | ❑ | Artificial Heart Valve |
| ❑ | ❑ | Asthma |
| ❑ | ❑ | Bleeding Problems or Bleeding Disorder |
| ❑ | ❑ | Cancer |
| ❑ | ❑ | Chemotherapy |
| ❑ | ❑ | Cold Sores |
| ❑ | ❑ | Congenital Heart Failure |
| ❑ | ❑ | Corticosteroid Treatment |
| ❑ | ❑ | Dental Phobia or Anxiety |
| ❑ | ❑ | Diabetes |
| ❑ | ❑ | Endocarditis |
| ❑ | ❑ | Epilepsy or Seizures |
| ❑ | ❑ | Fainting Spells or Dizziness |
| ❑ | ❑ | Heart Pacemaker |
| ❑ | ❑ | Heart Attack or Heart Problems |
| ❑ | ❑ | Hepatitis |
| ❑ | ❑ | History of Tobacco Use or Vaping |
| ❑ | ❑ | High Blood Pressure |

| Yes | No | |
|---|---|---|
| ❑ | ❑ | HIV or AIDS |
| ❑ | ❑ | HPV (Human Papilloma Virus) |
| ❑ | ❑ | Kidney Problems |
| ❑ | ❑ | Liver Problems |
| ❑ | ❑ | Lung Problems |
| ❑ | ❑ | Major Operations |
| ❑ | ❑ | Memory Problems |
| ❑ | ❑ | Osteoporosis / Osteopenia |
| ❑ | ❑ | Psychiatric Care |
| ❑ | ❑ | Respiratory Problems |
| ❑ | ❑ | Radiation Treatment |
| ❑ | ❑ | Rheumatic Fever |
| ❑ | ❑ | Sinus Problems |
| ❑ | ❑ | Stomach or Intestinal Problems |
| ❑ | ❑ | Stroke |
| ❑ | ❑ | Thyroid Problems |
| ❑ | ❑ | Tuberculosis |
| ❑ | ❑ | Tumors or Growths |
| ❑ | ❑ | If Female, Are you Pregnant? |
| ❑ | ❑ | Other Health Problems |

Please provide additional information for all "Yes" responses:

______________________

______________________

**Do you take any medications?** . . . . . . ❑ Yes ❑ No

If Yes, please list medications and the reason why you are taking them:

Medication: ________ Reason: ________ Medication: ________ Reason: ________

Medication: ________ Reason: ________ Medication: ________ Reason: ________

Medication: ________ Reason: ________ Medication: ________ Reason: ________

Medication: ________ Reason: ________ Medication: ________ Reason: ________

**Signature:** ______________________ **Date:** ________