# HEALTH HISTORY

**Patient's Name** **Date of Birth** **Date**

**Y N** Are you in good health? _____

**Y N** Has there been any change in your health in the past year? _____

Date of last physical exam: _____

**Y N** Are you under a physician's care for a particular problem? _____

_____

**DO YOU HAVE OR HAVE YOU EVER HAD:**

**Y N** Cardiovascular Disease (i.e. Heart Disease, High Blood Pressure, High Cholesterol: _____

**Y N** Lung Disease (i.e. Emphysema, COPD)? _____

**Y N** Breathing problems (i.e. Asthma, Sleep Apnea)? ____

**Y N** Seizures? _____

**Y N** Bleeding Disorder? _____

**Y N** Liver Disease (i.e. Jaundice, Hepatitis)? _____

**Y N** Kidney Disease? _____

**Y N** Diabetes?_____

**Y N** Thyroid Disease (i.e. Goiter)? _____

**Y N** Arthritis? _____

**Y N** Stomach Ulcers or Colitis? _____

**Y N** Glaucoma? _____

**Y N** Osteoporosis? _____

**Y N** Implants placed anywhere in your body? _____

**Y N** Radiation or Chemotherapy treatment for cancer?____

**Y N** TMJ (jaw joint) problems (grind or clench teeth)? ____

**Y N** Sinus or Nasal problems? _____

**Y N** Any disease or drug that depressed your immune system? _____

**Y N** Any psychiatric or emotional disorders? _____

**Y N** Any other medical conditions? _____

**Height** _____ **Weight** _____

**Y N Have you ever had any surgery?**

_____

_____

_____

**PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:**

_____

_____

_____

**Y N Any Allergies or Adverse reactions to medications or foods?** _____

_____

_____

**Y N** Do you smoke or chew Tobacco?
How much per day? _____

**Y N** Is there any past or present history of alcohol or drug dependency? _____

**Y N** Have you had any serious problems associated with any previous medical, surgical, dental or anesthetic treatment?

_____

**Y N** Do you have any other disease, condition or problem not listed above? _____

_____

**Y N** Do you wish to disclose any other information related to your health or your visit today? _____

_____

**FOR WOMEN ONLY:**

**Y N** Are you Pregnant, or is there any chance you might be Pregnant?

**Y N** Are you nursing?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**Pharmacy Information:**

Name:_____

Address: _____

Phone Number:_____

Notes (office use only):

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.**

_____ _____ _____

Date Signature of Patient (or legal guardian) Doctor's Initials