

1. Referring Dentist: _____ Physician: _____

2. Are you being treated by a physician now?..... Yes _____ No _____ Last visit _____
If yes, for what reasons? _____

3. Are you currently taking any prescription, nonprescription, or herbal **medications**? Yes _____ No _____
If yes, please list: _____ Birth control... Yes _____ No _____
Inhalers Yes _____ No _____

4. Have you ever taken Boniva, Fosamax, Actonel, Zometa, Aredia, Reclast, Didronel, Ostad or Bonefos?..... Yes _____ No _____
If yes, for how many years and when? _____

5. Do you have any **allergies** to:
A. Any drugs or medications?..... Yes _____ No _____ If yes, please list: _____

B. Local Anesthetics (Novocaine, etc.)..... Yes _____ No _____
C. Latex, Band-Aids, Tape..... Yes _____ No _____
E. Eggs or soybeans..... Yes _____ No _____

7. Do you have a joint replacement?..... Yes _____ No _____
If yes, when: _____

8. Do you have a current cold, cough, or sore throat? Yes _____ No _____

9. Do you or have you ever had:
Congenital Heart Disease (from birth)..... Yes _____ No _____
Congestive Heart Failure Yes _____ No _____
Cardiovascular Disease (heart trouble/blockage) Yes _____ No _____
Angina (chest pain) Yes _____ No _____
Heart Valve Replacement..... Yes _____ No _____
Bacterial Endocarditis..... Yes _____ No _____
Heart Murmur..... Yes _____ No _____
Mitral Valve Prolapse (MVP) Yes _____ No _____
Arrhythmia (irregular heart beat) Yes _____ No _____
Heart Attack..... Yes _____ No _____
If Yes, when? _____

Heart Surgery Yes _____ No _____
 Bypass when? _____ Stents when? _____ Pacemaker? _____
High Blood Pressure Yes _____ No _____ Myasthenia Gravis Yes _____ No _____
Low Blood Pressure..... Yes _____ No _____ Muscle Disorder..... Yes _____ No _____
Lung Disease..... Yes _____ No _____ Diabetes Yes _____ No _____
Asthma..... Yes _____ No _____ Thyroid Disease..... Yes _____ No _____
Bronchitis Yes _____ No _____ Glaucoma..... Yes _____ No _____
COPD/Emphysema..... Yes _____ No _____ Cancer Yes _____ No _____
Short of breath Yes _____ No _____ Type? _____
Sleep Apnea Yes _____ No _____ Radiation..... Yes _____ No _____
Stroke Yes _____ No _____ Chemotherapy Yes _____ No _____
Nervous Disorder..... Yes _____ No _____ Oral drugs for
Seizures..... Yes _____ No _____ cancer treatment Yes _____ No _____
Mental Disorder Yes _____ No _____ Bone Disease..... Yes _____ No _____
Anxiety Yes _____ No _____ Osteoporosis..... Yes _____ No _____
Eating Disorder..... Yes _____ No _____ Autoimmune Disease Yes _____ No _____
Blood Disorder..... Yes _____ No _____ Have you had an organ
Anemia Yes _____ No _____ or tissue transplant..... Yes _____ No _____
Bleeding Disorder..... Yes _____ No _____ Lupus..... Yes _____ No _____
Bleed or Bruise easily..... Yes _____ No _____ HIV..... Yes _____ No _____
Liver Disease..... Yes _____ No _____ Rheumatoid Arthritis..... Yes _____ No _____
Hepatitis..... Yes _____ No _____ Kidney Disease..... Yes _____ No _____

- 10. Do you have Temporomandibular Joint Disease (TMJ)?..... Yes No
- 11. Do you have difficulty opening your mouth?..... Yes No
- 12. Are you wearing any removable denture or plate?..... Yes No
- 13. Have you or anyone in your immediate family had difficulty with general anesthesia?..... Yes No
- 14. Do you or your family have a history of Malignant Hyperthermia?..... Yes No
- 15. Are you wearing contact lenses?..... Yes No
- 16. Are you wearing any oral or facial piercing?..... Yes No
- 17. Do you smoke?..... Yes No If yes, packs per day _____ How many years _____
- 18. Have you ever abused alcohol? Yes No
- 19. Have you ever used street/recreational drugs?..... Yes No

20. Please list previous hospitalizations and surgeries with approximate dates: _____

21. Do you have a disease or condition not mentioned above? Yes No
 If yes, please list: _____

22. If this office visit is a result of an accident, please give details:

23. Do you wish to talk with the doctor privately about anything? Yes No

Women Only:
 24. Are you pregnant or trying to become pregnant? Yes No
 If Yes, how many months? _____ Nursing? _____

* I understand the importance of a truthful health history to assist the doctor in providing the safest care possible.

Person completing health history: _____

Relationship to patient: _____

Signature: _____ Date: _____

Medical History Updated:
 Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____