5 HEALTH HISTORY

Physician's Name _____Date of last visit_____

Have you ever taken Fosamax or any other bisphosphonate (bone building medication) for osteoporosis? ☐Yes ☐No

Have you ever had any of the following?

AIDS/HIV	☐Yes ☐No	Fainting /dizziness	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Arthritis/ Rheumatism	☐Yes ☐No	Headaches	☐Yes ☐No	Rheumatic Heart Disease	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Problems	☐Yes ☐No	Sexually Transmitted Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis Type ___	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Back Problems	☐Yes ☐No	Herpes	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Abnormal Bleeding	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Skin Rash	☐Yes ☐No
Bruising	☐Yes ☐No	Jaundice	☐Yes ☐No	Special Diet	☐Yes ☐No
Blood Disease	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Night Sweats	☐Yes ☐No		
Cough, persistent or bloody	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Ulcer	☐Yes ☐No
Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Weight Loss (unexplained)	☐Yes ☐No
Emphysema	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Women (check all that apply)	
Epilepsy	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Pregnant	☐Yes ☐No
				Nursing	☐Yes ☐No
Do you wear contact lenses	☐Yes ☐No			Birth Control	☐Yes ☐No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Aspirin	☐Yes ☐No	Local Anesthetic	☐Yes ☐No
Barbiturate	☐Yes ☐No	Penicillin	☐Yes ☐No
Codeine	☐Yes ☐No	Sulfa	☐Yes ☐No
Iodine	☐Yes ☐No	Other_____	
Latex	☐Yes ☐No		

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions?_____

Are you taking any new medications? If so, what?_____

Patient's Signature_____

Doctor's Signature_____

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions?_____

Are you taking any new medications? If so, what?_____

Patient's Signature_____

Doctor's Signature_____