

HEALTH HISTORY

Patient's Name _____ Today's Date _____

Physician's Name _____ Date of Last Visit _____

Have you ever been told by a physician to take antibiotics before your dental appointment?

Yes No

Are you currently taking or have you ever taken bisphosphonate medications, including but not limited to, Fosomax, XGEVA, Prolia, Reclast, Boniva, Zometa, Actonel, Didronel, Aclasta, Aredia, Atelvia, and/or Binosta?

Yes No

MEDICATIONS Check one of the following

I do not take any prescription medications, over-the-counter medications, dietary supplements or herbal remedies

OR, I am providing a copy of my complete and current list of medications

ALLERGIES

Aspirin Barbiturates (sleeping pills) Codeine Erythromycin Epinephrine Iodine Latex

Penicillin Sulfa Other _____ OR No Known Drug Allergies

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

- | | | | | | |
|---------------------------|--|-------------------------|--|-----------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | STD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type A B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding, Abnormally with | | Herpes Type I or II | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease/Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease/Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or Growth on | |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease/Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, Persistent/bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Disease/Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes Type I | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>For Women, Pregnancy</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes Type II | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Birth Control Pills | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nursing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Fainting/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain any "YES" answers from the above questions _____

I have general authority to perform all acts on my own behalf and I am responsible for my own decisions.

No other person or persons holds a Power of Attorney on my behalf.

Patient (print): _____ **Signature:** _____ **Date:** _____