PATIENT HEALTH HISTORY

Patient: ___________________ Date: _________

Who is your dentist? ___________________
When was your last: dental visit? ________________ cleaning? ________________
Do you have any periodontal (gum) problems (i.e. gum disease, deep pockets, etc.)? Yes No
If so, please explain: ______________________________

Have you ever had or currently have any of the following? (Circle YES or NO)

Heart Murmur	Yes	No	High blood pressure	Yes	No
Rheumatic Fever	Yes	No	Low blood pressure	Yes	No
Prosthetic joint replacement	Yes	No	Diabetes	Yes	No
Heart valve replacement	Yes	No	Anemia	Yes	No
Heart stent	Yes	No	Glaucoma	Yes	No
			Tuberculosis	Yes	No
Osteoporosis	Yes	No	Cancer	Yes	No
Osteopenia	Yes	No	Kidney disease	Yes	No
Multiple myeloma	Yes	No	HIV infection	Yes	No
Bone metastases of cancer	Yes	No	Endocrine problems	Yes	No
Hypercalcemia	Yes	No	Nervous disorders	Yes	No
Paget's disease	Yes	No	Liver disease	Yes	No
Radiation therapy	Yes	No	Prolonged bleeding	Yes	No
			Bone disorders	Yes	No
Seizure disorders	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	AIDS	Yes	No
Fainting	Yes	No	Heart problems	Yes	No
Other ___________________	Yes	No			

Do you need to take antibiotics before your dental appointments? Yes No If so, why? _____________
Have you been under the care of a physician in the past 2 years? Yes No If so, why? _____________

Are you taking or have you EVER taken <u>bisphosphonates</u> (including but not limited to Fosamax®, Fosamax plus D®, Didronel®, Boniva®, Aredia®, Skelid®, Zometa®, etc)?
Yes No If so, which one(s)? _____________________

List any drugs or medications now being taken (including birth control medications):
Medication ________________ Taken for ________________
Medication ________________ Taken for ________________

Have you ever been hospitalized? Yes No If so, for what? ________________________

Do you have allergies to any of the following (if so, explain in detail next to the item):

Local anesthetics	Yes	No	Aspirin	Yes	No
Ibuprofen	Yes	No	Penicillin or other antibiotics	Yes	No
Sulfa drugs	Yes	No	Codeine or other narcotics	Yes	No
Metals (jewelry, etc)	Yes	No	Vinyl	Yes	No
Latex (gloves, balloons, etc)	Yes	No	Acrylic	Yes	No
Foods (specify)___________	Yes	No	Other (specify)___________	Yes	No

Are you pregnant? Yes No
Has there ever been an injury to the face, jaw, or teeth? Yes No If so, explain? ___________________
Has there ever been a thumbsucking habit? Yes No If so, until what age? ______________
Are there any speech problems? Yes No
Are there any TMJ (jaw joint) problems? Yes No If yes, explain ___________________
Is there anything else we should know (whether it be medically, socially, or religiously related) about this patient that hasn't otherwise been addressed? Yes No If so, please explain: ______________

Signature of Patient, Parent, or Legal Guardian: _____________________________ Date: __________