PATIENT NAME_____**DATE**_____
LAST FIRST

Reason for visit today:_____

1. Are you in good health?.....Y N

2. Have there been any changes in your general health in the past year?.....Y N

3. Are you under a physician's care?.....Y N-----If yes, explain_____

4. Name of physician(s):_____

5. Do you have any of the following conditions? Check Yes or No

Rheumatic fever disease	Y	N	Congenital heart disease	Y	N
Heart attack	Y	N	Heart murmur/Mitral valve	Y	N
Coronary artery disease	Y	N	Angina (chest pain)	Y	N
Heart surgery	Y	N	Pacemaker	Y	N
High blood pressure	Y	N	Stroke	Y	N
Asthma	Y	N	Emphysema	Y	N
Chronic cough	Y	N	Bronchitis	Y	N
Pneumonia	Y	N	Shortness of breath	Y	N
Sinus/nasal problems	Y	N	Seizures	Y	N
Convulsions	Y	N	Epilepsy	Y	N
Fainting	Y	N	Psychiatric treatment	Y	N
Dizziness	Y	N	Nervous disorder	Y	N
Bleeding disorder	Y	N	Anemia	Y	N
Blood transfusion	Y	N	Bruising easily	Y	N
Liver disease	Y	N	Hepatitis, Type	Y	N
Kidney disease	Y	N	Diabetes	Y	N
Thyroid disease	Y	N	Arthritis	Y	N
Stomach ulcer/colitis	Y	N	Glaucoma	Y	N
Artificial joints/implants	Y	N	Radiation treatment	Y	N
Chemotherapy	Y	N	Mouth sores	Y	N
Popping in jaw	Y	N	Pain in ear	Y	N
Difficulty opening mouth	Y	N	Grinding/clenching teeth	Y	N

6. If you have had or presently have a condition, illness, operation, or hospitalization not listed above-Please describe:_____

7. If you have asthma, do you have your inhaler with you?_____

8. Please list all medications taken at this time:_____
_____
_____

9. Have you been on any biphosphonates currently or in the past? If so, please circle which type.
(Oral) Actonel Boniva Fosamax Skelif Didronel **(I.V)** Aredia Zometa

10. Have you been on any chemotherapy medications currently or in the past? Yes or No
List name of medcation:_____

11. Please list any medications you are allergic to:

_____
_____
_____

12. Are you pregnant?.....Y N
13. Do you smoke?.....Y N **14.** Do you chew tobacco?.....Y N

DENTAL HISTORY

Is your condition causing you discomfort?..... Y N
Do you have swelling?.....Y N
Is this the result of trauma? If yes, describe_____ Y N
Do you feel nervous about dental treatment?.....Y N
Have you ever had a bad experience in a dental office?.....Y N
Do you have other dental problems?.....Y N
Does your jaw ever lock, pop, or click?.....Y N
Are your teeth sensitive?.....Y N

Is there anything you wish to discuss privately with the doctor? Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my medical history, dental history, or if my medications change, I will inform the doctor. I understand that failure to disclose any medical condition may jeopardize my life.

_____ _____
Signature of Person Completing Health History **Date**

MEDICAL UPDATE

_____

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