Health History

Answer all questions by circling Yes (Y) or No (N):

1. Are you in good health?..... **Y** **N**
2. Has there been any change in your general health in the past year?..... **Y** **N**
3. Are you now under a physician's care for any particular problem?..... **Y** **N**
4. Have you **ever** had any serious illnesses, operations or hospitilaztions? ..... **Y** **N**

If Yes, please describe:

Do you have or have you ever had?:

1. Cardiovascular Disease (Heart Attack, Heart Trouble, Coronary Artery Disease, Heart Surgery, Pacemaker, Angina, High Blood Pressure, Stroke, Heart Murmur)?..... **Y** **N**
2. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis)?..... **Y** **N**
3. Seizures, Convulsions, or Epilepsy?..... **Y** **N**
4. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion or Do you bruise easily?..... **Y** **N**
5. Rheumatic Fever or Congenital Heart Disease?..... **Y** **N**
6. Liver Disease, Jaundice, or Hepatitis?..... **Y** **N**
7. Kidney Disease?..... **Y** **N**
8. Diabetes?..... **Y** **N**
9. Thyroid Disease?..... **Y** **N**
10. Arthritis?..... **Y** **N**
11. Stomach Ulcers or Colitis?..... **Y** **N**
12. Glaucoma?..... **Y** **N**
13. Osteoporosis?..... **Y** **N**
14. Implants placed anywhere in your body?..... **Y** **N**
15. Radiation treatment for Cancer?..... **Y** **N**
16. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..... **Y** **N**
17. Sinus or Nasal problems?..... **Y** **N**
18. Any disease, drug, or transplant operation that has depressed your immune system?..... **Y** **N**
19. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?..... **Y** **N**

If Yes, please describe:

Are you using any of the following?:

1. Antibiotics?..... **Y** **N**
2. Anticoagulants (Blood Thinners)?..... **Y** **N**
3. Aspirin or drugs such as Motrin, Aleve, Ibuprofen..... **Y** **N**
4. Steroids (Cortisone, Prednisone, etc.)?..... **Y** **N**
5. Insulin or Oral Anti-Diabetic Drugs?..... **Y** **N**
6. Are you taking/have you ever taken Bisphosphonates for Osteoporosis, Multiple Myeloma, or other Cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?..... **Y** **N**
7. **Please list any and all medications taken:**

☐ **See List**

8. **Do you pre-medicate for dental work?..... Y N**

*** DO YOU HAVE ANY ALLERGIES TO DRUGS OR FOOD?..... Y N**

IF YES, PLEASE LIST:

1. Do you smoke or chew tobacco?..... **Y** **N**
   If yes , How much per day?_____
2. Is there any past history of alcohol, chemical dependency, or emotional disorder that may affect the care we provide you?..... **Y** **N**
3. Have you or an immediate family member ever had any problems associated with general anesthesia?..... **Y** **N**

For Women Only:

1. Are you pregnant, or is there any chance that you might be pregnant?..... **Y** **N**
2. Are you nursing?..... **Y** **N**
3. Are you taking oral contraceptive pills?..... **Y** **N**

I, the undersigned, attest to the validity of the foregoing personal and medical history.

PATIENT SIGNATURE

DATE

(OR SIGNATURE OF PARENT OR LEGAL GUARDIAN IF PATIENT IS MINOR)