Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date _____
Last First MI (Preferred Name)

Birth Date: _____ Age:____ Gender: _____ Family Status: _____
Social Security #: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____
E-mail: _____
Address: _____
_____

Health Information

Personal physician: _____ City: _____ Phone #: _____

Height: _____ Weight: _____ How would you describe your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized or needed emergency care in the past five years? …….. ☐ Yes ☐ No
If yes, please explain: _____

Is there any activity that your physician says you cannot do? …….. ☐ Yes ☐ No
If yes, please explain: _____

Have you ever taken any anti-resorptive medication to treat osteoporosis or other bone disease? …….. ☐ Yes ☐ No
Includes **bisphosphonates** *(Actonel, Atelvia, Zometa, Didronel, Fosamax, Boniva, Aredia, Skelid, Reclast)*
And **RANK ligand inhibitors** *(Denosumab, AKA Prolia or Xgeva)*

Do you have or have you ever had any of the following conditions? **Please check Yes or No** and **circle all that apply**.

Yes No
__ ☐ **HEART DISEASE**
Congestive heart failure
Congenital heart malformation
Valve problems / murmur
CAD / chest pain / angina
Heart attack / MI
Irregular heart beat / pacemaker
Infective endocarditis

Yes No
☐ **VASCULAR / BLOOD DISEASE**
High blood pressure
Low blood pressure
Atherosclerosis
Anticoagulant therapy
Bleeding disorder

Yes No
☐ **LUNG / AIRWAY DISORDER**
Asthma
COPD / bronchitis / emphysema
Pneumonia, tuberculosis
Shortness of breath
Sleep apnea

Yes No
☐ **KIDNEY DISEASE**
Acute or chronic renal failure
Dialysis

Yes No
☐ **LIVER DISEASE**
Hepatitis (A,B,C, autoimmune)
Cirrhosis

Yes No
☐ **DIGESTIVE TRACT DISORDER**
Acid reflux / heartburn
Ulcers / GI bleeding
Colitis, Crohn's, IBS, Diarrhea

Yes No
☐ **ENDOCRINE DISORDER**
Thyroid disease
Diabetes
Adrenal gland disorder
Gender hormone therapy

Yes No
☐ **PSYCHIATRIC / BEHAVIORAL**
Psychiatric illness
Nervousness / anxiety
Depression

Yes No
☐ **IMMUNOLOGIC DISORDER**
Rheumatoid arthritis
Lupus erythematosus
Sjogren's syndrome
Other autoimmune disease
Immunosuppressive therapy
Use of prednisone or similar

Yes No
__ ☐ **NEUROLOGICAL DISORDER**
Seizures / epilepsy
Parkinson's disease
Cerebral palsy
Stroke / TIA
Neuralgia

Yes No
☐ **CANCER**
Type: _____
Radiation therapy
Chemotherapy
Surgery

Yes No
☐ **MUSCULOSKELETAL**
Osteoporosis
Artificial joints
Joint pain
Swollen ankles

Yes No
☐ **HEAD / NECK**
Injury to face, jaws, neck
TMJ disorder
Sinus trouble
Headaches / migraines

Yes No
__ ☐ **INFECTIOUS DISEASE**
HIV+ / AIDS
Cold sores / fever blisters
Sexually-transmitted disease
Other infectious disease

Yes No
☐ **HABITS (Current / Former)**
Tobacco use
Marijuana use
Alcohol abuse
Drug abuse (street, prescription)

Do you have any other medical condition or had any major surgery that was not addressed above? ……..... ☐ Yes ☐ No

If yes, please explain:

Are you currently taking any medications? ……..…….…….……..... ☐ Yes ☐ No

If yes, please list all medications that you are currently taking, including over-the-counter and herbal products:

Drug name:	Dose / Frequency of use:	Reason for taking:

Do you have any known allergies or bad reactions to any medication or other substance……...? ☐ Yes ☐ No

If yes, please describe below:

To what:	Type of reaction:	Reaction severity:

FOR WOMEN: Some medications used in dentistry cross the placenta and breast milk, and might affect the unborn baby. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? ….....☐ Yes, _____ weeks
….....☐ No
….....☐ Possibly

Are you currently breastfeeding? ….. ☐ Yes ☐ No

Do you take birth control pills? ……. ☐ Yes ☐ No

FOR DOCTOR'S USE:

I have read and understand the questions on the health history. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ Date: _____

Signature of patient, parent, or guardian

_____

Relationship to patient, if applicable