

Personal Health History

Do you have a personal physician? Yes No

Physician's Name: _____ Contact Number: _____

Have you been treated by a physician in the past year? Yes No

If yes, please explain: _____

Do you smoke or use tobacco in any other form? Yes No

If yes, cigarettes per day: _____ Number of years: _____

Are you allergic to any medications? Yes No

If yes, please describe: _____

Your current physical health is: Good Fair Poor

Have you been hospitalized in the past 5 years? Yes No

If yes, please explain: _____

Have you ever had a general anesthetic? Yes No

Have you had surgery in the past 5 years? Yes No

If yes, please explain: _____

Please list all medication (including frequency and dose) that you are presently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you taking any blood thinners (Coumadin/Warfarin, Plavix, Aspirin)? Yes No

Please list: _____

Do you take or have you ever taken bisphosphonate medications (Fosamax, Actonel) for osteoporosis or cancer treatment? Yes No

Have you ever had radiation or chemotherapy? Yes No

Do you have any artificial joints or prosthetic implants? Yes No

Have you had a heart valve replacement (artificial heart valve)? Yes No

For women only:

Are you taking the birth control pill? Yes No

Are you currently pregnant or is it possible that you could be pregnant? Yes No

Are you nursing? Yes No

Have you had or currently have any of the following medical issues:

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack or Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A,B,C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease / Trait	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone, Prednisone or Steroid Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Bruise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal/Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Office Use Only:

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: ____ / ____ / ____
MM DD YYYY

Changes in health status since last visit:

Initials: _____ Date: ____ / ____ / ____
MM DD YYYY