Health History Form



| Name  Address: | | | Phone # |
| --- | --- | --- | --- |
| Preferred Method of Contact *(Circle all that Apply)*: Text Call Email | | | |

| Please answer the following to the best of your ability: | | | |
| --- | --- | --- | --- |
| Are you under a physician’s care? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever been hospitalized or had a major operation? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you required to take a pre-medication (antibiotic)? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had a serious head or neck injury? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you taking any medication, pills, or drugs? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever taken medications containing bisphosphonates (Fosamax, Boniva, Actonel, etc.)? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you, or have you taken, Phen-Fen or Redux? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use controlled substances? Other? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use tobacco? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you or have you taken Blood Thinning medications? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you or have you taken medication for Osteoporosis? | * Yes | * No | If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



| Are you… | | | Are you allergic to any of the following? | | |
| --- | --- | --- | --- | --- | --- |
| Pregnant/Trying to get Pregnant? | * Yes | * No | Aspirin | Penicillin | Codeine |
| Nursing? | * Yes | * No | Metal | Latex | Sulfa Drugs |
| Taking Oral Contraceptives? | * Yes | * No | Local anesthetics | Acrylic | Other: \_\_\_\_\_\_\_\_\_\_\_ |

| Do you, or have you had, any of the following? *(Please circle whatever applies)* | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| AIDS/HIV Positive | Blood Transfusions | Diabetes | Glaucoma | Irregular Heartbeat | Parathyroid Disease | Sinus Trouble |
| Alzheimer’s Disease | Breathing Problems | Drug Addiction | Hay Fever | Kidney Problems | Psychiatric Care | Stomach or Intestinal |
| Anaphylaxis | Bruise Easily | Easily Winded | Heart Attack or Trouble | Leukemia | Radiation Treatments | Stroke |
| Anemia | Cancer | Emphysema | Heart Murmur | Liver Disease | Recent Weight Loss | Swelling of Limbs |
| Angina | Chemotherapy | Epilepsy or Seizures | Hepatitis A | Low Blood Pressure | Renal Dialysis | Thyroid Disease |
| Arthritis/Gout | Chest Pains | Excessive Bleeding | Hepatitis B or C | Lung Disease | Rheumatic Fever | Tonsillitis |
| Artificial Heart Valve | Cold Sores/Fever | Excessive Thirst | Herpes | Mitral Valve Prolapse | Rheumatism | Tuberculosis |
| Artificial Joint | Congenital Heart | Fainting | High Blood Pressure | Osteoporosis | Scarlet Fever | Tumors or Growths |
| Asthma | Convulsions | Frequent Cough | High Cholesterol | Pacemaker | Shingles | Ulcers |
| Blood Disease | Cortisone Medication | Frequent Headaches | Hives/Rash | Pain in Jaw Joints | Sickle Cell Disease | Yellow Jaundice |
| Other Not Listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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Patient/Legal Guardian Signature Date

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Provider Signature Date