Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your dental record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Attending physician: **Phone**:	**Date of last physical exam:**
Are you under physician's care now? ☐Y ☐N	**If so, for what?**

PERSONAL HEALTH HISTORY

Have there been any problems in your general health within the past 5 yrs.?	☐ Yes	☐ No
If so, what was the problem?		

Please list any surgeries you have had:		
Year	Reason	Hospital

Other hospitalizations:		
Year	Reason	Hospital

Have you ever had any form of cancer?	☐ Yes	☐ No
If so, what type?		
Have you ever taken oral or IV bisphophonates such as Fosamax, Zometa, Aredia, or Actonel?	☐ Yes	☐ No
Does your physician require you to take special medicine before a dental appointment?	☐ Yes	☐ No
If so, for what?		
Are you allergic to metals? What type?		
Do you have any allergies to medications? Please list:		
Are you pregnant?	☐ Yes	☐ No
Are you taking Coumadin or any other blood thinners?	☐ Yes	☐ No

Check if you have or have had the following:

- ☐ Aids or HIV+
- ☐ Alcohol Dependecy
- ☐ Allergies
- ☐ Artificial Joints
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, C, please circle)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Bruise Easily
- ☐ Chewing Tobacco
- ☐ Chronic Fatigue Syndrome
- ☐ Low Blood Pressure
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Prolonged Healing
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ Disorder
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal disease

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

I understand that this medical history is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient or Legal Guardian **X**_____