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 bisphosphoneate 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	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Intestinal Problems	☐ Yes ☐ No
Heart Attack or Disease	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	Gastrointestinal Ulcers	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hepatitis A,B,C	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	HIV / AIDS	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Sickle Cell Disease / Trait	☐ Yes ☐ No	Cortisone, Prednisone or Steroid Therapy	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Easily Bruise	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Abnormal/Prolonged Bleeding	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ 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