Health History Form

E-mail

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

First Name

Last Name

MI

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

Home Phone

Cell Phone

MEDICAL INFORMATION

For the following questions, please mark (X) your responses.

Are you currently under the care of a physician? Yes ○ No ○

Physician Name

Phone

Address/City/State/Zip

Are you in good health? Yes ○ No ○

Has there been any change in your general health within the past year? Yes ○ No ○

If yes, what condition is being treated?

Date of last physical exam

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes ○ No ○

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ○ No ○

Do you take any blood thinners? Yes ○ No ○

Do you take aspirin on a regular basis? Yes ○ No ○

If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

For the following questions mark (x) your responses

Do you use controlled substances (drugs)? Yes ○ No ○

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ○ No ○

If so, how interested are you in stopping?

○ VERY ○ SOMEWHAT ○ NOT INTERESTED

Do you drink alcoholic beverages? Yes ○ No ○

If yes, how much alcohol did you drink in the last 24 hours?

WOMEN ONLY Are you: Yes No

Pregnant? Yes ○ No ○

Number of weeks

Taking birth control pills or hormonal replacements? Yes ○ No ○

Nursing? Yes ○ No ○

Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ○ No ○

If yes, date

If yes, have you had any complications?

Allergies: Are you allergic or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics	○	○	Metals	○	○
Aspirin	○	○	Latex (rubber)	○	○
Penicillin or other antibiotics	○	○	Iodine	○	○
Barbiturates, sedatives, or sleeping pills	○	○	Hay fever/seasonal	○	○
Sulfa drugs	○	○	Animals	○	○
Codeine or other narcotics	○	○	Food/Other	○	○

If yes, please specify

MEDICAL INFORMATION *(Continued)*

Please mark (X) your response if you have or have had any of the following diseases or problems.

	Yes	No
Heart murmur	○	○
Mitral valve prolapse	○	○
Artificial heart valves	○	○
Rheumatic fever	○	○
Cardiovascular disease	○	○
Angina	○	○
Arteriosclerosis	○	○
Congestive heart failure	○	○
Coronary artery disease	○	○
Damaged heart valves	○	○
Heart attack	○	○
Low blood pressure	○	○
High blood pressure	○	○
Congenital heart defects	○	○
Pacemaker	○	○
Rheumatic heart disease	○	○
Abnormal bleeding	○	○
Anemia	○	○
Blood transfusion	○	○
If yes, date		
Hemophilia	○	○
AIDS or HIV infection	○	○
Arthritis	○	○
Autoimmune disease	○	○
Rheumatoid arthritis	○	○
Systematic lupus erythematosus	○	○
Asthma	○	○
Bronchitis	○	○
Emphysema	○	○
Sinus trouble	○	○
Tuberculosis	○	○
Cancer/Chemotherapy/ Radiation treatment	○	○
Chest pain upon exertion	○	○
Chronic pain	○	○
Diabetes type I or type II	○	○
Eating disorder	○	○
Malnutrition	○	○
Gastrointestinal disease	○	○
GE Reflux/persistent heartburn	○	○
Ulcers	○	○
Thyroid problems	○	○
Stroke	○	○
Glaucoma	○	○
Hepatitis, jaundice, or liver disease	○	○
Epilepsy	○	○
Fainting spells/seizures	○	○
Neurological disorders	○	○
If yes, please specify		
Gag Reflex Sensitivity	○	○
Sleep disorder	○	○
Mental health disorders	○	○
If yes, please specify		
Recurrent infections	○	○
If yes, type of infection		
Kidney problems	○	○
Night sweats	○	○
Osteoporosis	○	○
Persistent swollen glands in neck	○	○
Severe headache/migraines	○	○
Severe/rapid weight loss	○	○
STDs/STIs	○	○
Excessive urination	○	○
ADD	○	○
ADHD	○	○
Sensory Processing Disorder	○	○
Oral Sensory Sensitivity	○	○

	Yes	No
Has a physician recommended that you take antibiotics prior to your treatment?	○	○
Do you have any disease, condition, or problem not listed above that you think I should know about?	○	○

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

FOR COMPLETION BY OFFICE

Comments: