

## HEALTH HISTORY

Patient Name: \_\_\_\_\_

FIRST

LAST

DOB: \_\_\_\_\_

### General Health Information

Are you currently under the care of a physician?

☐ Yes ☐ No

Physician phone number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Are you presently being treated for any injury or illness?

☐ Yes ☐ No

Have you ever been hospitalized for an injury or illness?

☐ Yes ☐ No

Are you pregnant or planning to become pregnant?

☐ Yes ☐ No

Are you currently breastfeeding?

☐ Yes ☐ No

Are you required to pre-med with antibiotics before dental treatment?

☐ Yes ☐ No

Do you use alcohol?

☐ Yes ☐ No

Do you use or have you ever used tobacco?

☐ Yes ☐ No

### Allergies

Are you allergic to any of the following? Please check any that apply:

☐ No Known Allergies☐ Anesthetic ☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa☐ Other - Please list any other allergies or allergic reactions you may have: \_\_\_\_\_

### Medical Conditions

Please check all conditions that you have history of or are currently being treated for:

Do you have a history or are currently being treated for any Digestive conditions?

☐ Yes ☐ No

Do you have a history or are currently being treated for any Heart or Circulatory conditions?

☐ Yes ☐ No

Do you have a history or are currently being treated for any Neurological conditions?

☐ Yes ☐ No

Do you have a history or are currently being treated for any Lung or Breathing conditions?

☐ Yes ☐ No

Do you have a history or are currently being treated for any Autoimmune conditions?

☐ Yes ☐ No

Head or neck injuries?

☐ Yes ☐ No

Artificial Joint or revision surgery of joint? If yes, when?

☐ Yes ☐ No

High cholesterol?

☐ Yes ☐ No

History of cancer?

☐ Yes ☐ No

Tumor or abnormal growth?

☐ Yes ☐ No

Radiation therapy?

☐ Yes ☐ No

Chemotherapy?

☐ Yes ☐ No

HIV / AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis / osteopenia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type I or Type II diabetes? Latest A1c and date	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Measles / chicken pox?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other medical condition we should know of? If yes, please list below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Medications

**Please check all medications you are currently taking:**

Are you taking any pain medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any Antidepressants or Anxiety medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any Allergy or Asthma medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any Antibiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently taking any other medications or dietary supplements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Please list all medications you are currently taking in the spaces below:**

**\*\*EXISTING PATIENTS\*\*** Check the box next to any medication no longer being taken.

1. <input type="checkbox"/>	6. <input type="checkbox"/>
2. <input type="checkbox"/>	7. <input type="checkbox"/>
3. <input type="checkbox"/>	8. <input type="checkbox"/>
4. <input type="checkbox"/>	9. <input type="checkbox"/>
5. <input type="checkbox"/>	10. <input type="checkbox"/>

Patient/Guardian Signature:

Date: 09/16/2025

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Doctor Signature:

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