Confidential Patient History

Name:	DOB	Age	Sex

Has there been any change in your general health in the past year? If yes, please describe.

Are you now under a physician's care for a particular problem? If yes, what?

Have you ever had any serious illnesses, operations, or hospitalizations? If yes, please describe.

Do you have or have you ever had any disease, drugs, transplant operations that depressed your immune system? (Specify)

1. Do you have or have you ever had:

Rheumatic fever or rheumatic heart disease	❑Y	❑N
Congenital heart disease	❑Y	❑N
Cardiovascular disease (high blood pressure, heart trouble/attack, murmur, angina, stroke, coronary artery disease, palpitations, surgery, pacemaker, etc.)	❑Y	❑N
Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing, etc.)	❑Y	❑N
Neurological or psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder, breakdown, etc.)	❑Y	❑N
Blood disease (anemia, bruise easily)	❑Y	❑N
Liver disease	❑Y	❑N
Kidney disease	❑Y	❑N
Diabetes A1C level _____	❑Y	❑N
Thyroid disease (goiter)	❑Y	❑N
Arthritis	❑Y	❑N
Stomach ulcers or colitis	❑Y	❑N
Glaucoma	❑Y	❑N
Frequent or recurring mouth sores	❑Y	❑N
Radiation for cancer	❑Y	❑N
Cancer treatment, chemotherapy, etc.	❑Y	❑N
Sinus or nasal problems	❑Y	❑N
Recurrent infections of any kind	❑Y	❑N
AIDS or HIV+	❑Y	❑N

2. If applicable, list all implants you have (heart valve, hip, knee, etc.)

3. Are you allergic to or have you had a bad reaction to:

Local anesthetic (Novocaine, etc.)	❑Y	❑N
Antibiotics (specify under #4 below)	❑Y	❑N
Sedatives or general anesthesia.	❑Y	❑N
Aspirin	❑Y	❑N
Codeine or other pain killers	❑Y	❑N
Latex	❑Y	❑N

4. Other allergies or reactions? (Specify)

5. Are you using or taking any of the following at any time, whether occasionally or regularly?

Cancer treatment, chemotherapy, etc.	❑Y	❑N
Anticoagulants (blood thinners)	❑Y	❑N
High blood pressure medicine	❑Y	❑N
Steroids	❑Y	❑N
Tranquilizers	❑Y	❑N
Insulin, oral therapy	❑Y	❑N
Digitalis, Inderal, Nitroglycerin or other heart medicine	❑Y	❑N
Aspirin? How much daily?	❑Y	❑N
Marijuana or other "street drugs"	❑Y	❑N
Women: birth control pills	❑Y	❑N
Inhalers		

Please list all medications, including prescription, over the counter, vitamin and herbal supplements.)

6. Women: Are you pregnant or planning pregnancy? ❑Y ❑N

7. Do you have any other disease, condition, or problem not listed? (Specify) ❑Y ❑N

8. Do you snore? ❑Y ❑N

9. Do you use tobacco? If so, what type? _____ ❑Y ❑N

10. Do you drink alcohol? If so, how much? _____ ❑Y ❑N

11. Have you ever sought professional care for drug abuse, alcoholism, or an emotional disorder? ❑Y ❑N

12. Do you have clicking or popping of your jaw joint? ❑Y ❑N

13. Do you have difficulty opening your mouth? ❑Y ❑N

14. Do you have any speech or hearing problems? ❑Y ❑N

I understand the importance of providing a truthful health history to assist my doctor in providing the best possible care. This information is complete and accurate.

Signature **Date**