----------HEALTH HISTORY----------

Patient's Name_____Today's Date_____

Physician's Name_____Date of Last Visit_____

Have you ever been told by a physician to take antibiotics before your dental appointment?

☐Yes ☐No

Are you currently taking or have you ever taken bisphosphonate medications, including but not limited to, Fosomax, XGEVA, Prolia, Reclast, Boniva, Zometa, Actonel, Didronel, Aclasta, Aredia, Atelvia, and/or Binosta?

☐Yes ☐No

MEDICATIONS Check *one* of the following

☐ I do not take any prescription medications, over-the-counter medications, dietary supplements or herbal remedies

☐ OR, I am providing a copy of my complete and current list of medications

ALLERGIES

☐ Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Erythromycin ☐ Epinephrine ☐ Iodine ☐ Latex

☐ Penicillin ☐ Sulfa ☐ Other _____ OR ☐ No Known Drug Allergies

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Headaches	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Anemia	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Arthritis/Rheumatism	☐Yes ☐No	Heart Attack	☐Yes ☐No	Skin Rash	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Heart Problems	☐Yes ☐No	Special Diet	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Surgery	☐Yes ☐No	STD	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Stomach Problems	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis Type A B or C	☐Yes ☐No	Stroke	☐Yes ☐No
Bleeding, Abnormally with		Herpes Type I or II	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Extractions or surgery	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Blood Disease	☐Yes ☐No	Jaundice	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Cancer	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Kidney Disease/Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Liver Disease/Problems	☐Yes ☐No	Tumor or Growth on	
Circulatory Problems	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Head or neck	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Lung Disease/Problems	☐Yes ☐No	Ulcer	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Cough, Persistent/bloody	☐Yes ☐No	Nervous Disease/Problem	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No
Diabetes Type I	☐Yes ☐No	Pacemaker	☐Yes ☐No	*For Women*, Pregnancy	☐Yes ☐No
Diabetes Type II	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Birth Control Pills	☐Yes ☐No
Emphysema	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Nursing	☐Yes ☐No
Epilepsy/Seizures	☐Yes ☐No	Respiratory Disease	☐Yes ☐No		
Fainting/Dizziness	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No		
Glaucoma	☐Yes ☐No	Scarlet Fever	☐Yes ☐No		

Please explain any "YES" answers from the above questions_____

_____

_____

I have general authority to perform all acts on my own behalf and I am responsible for my own decisions.

No other person or persons holds a Power of Attorney on my behalf.

PATIENT'S SIGNATURE_____**DATE**_____