# HEALTH HISTORY

Patients Name: Today`s Date: All responses kept confidential

Answer all questions by circling Yes (Y) or No (N)

1. Age_____ Height_____ Weight_____
2. Are you in good health ..... Y N
3. Has there been any change in your general health in the past year ..... Y N
4. Have you ever had any serious illnesses operations or hospitalizations? If so, describe ..... Y N

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5. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Seizures, Fainting or Dizzinesss ..... Y N
   B. Rheumatic Fever, Rheumatic Heart Disease, Congenital Heart Disease, Cardiovascular Disease, Heart Attack, Heart Trouble, Heart Murmer, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker..... Y N

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   C. Lung Disease ( Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath) .....Y N

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   D. Stomach Ulcers or Colitis .....Y N
   E. Liver Disease (Jaundice, Hepititis, Cirrhosis).....Y N
   F. Kidney Disease.....Y N
   G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Do you bruise easily? .....Y N

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   H. Diabetes Type I, Type II .....Y N
   I. Thyroid Disease (Hypothyroid, Hyperthyroid).....Y N
   J. Arthritis.....Y N
   K. Glaucoma.....Y N
   L. Implants placed anywhere in your body ( Heart Valve, Pacemaker, Hip, Knee).....Y N
   M. Radiation (X-ray) treatment for Cancer.....Y N
   N. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth.....Y N
   O. Sinus or Nasal Problems .....Y N
   P. Any disease, drug or transplant operation that has depressed your immune system .....Y N

6. Are you presently taking, or have you ever taken any of the following medicines and for how long.....?
   Alendronate (Fosamax), Zoledronic Acid (Reclast), Prolia / Xgeva (Denosumab), Etidronate (Didronel), Tiludronate (Skelid), Risedronate (Actonel), Remicode (Infliximab), Ibandronate (Boniva), Pmidronate (Aredia), Zoledronate (Zometa), .....Y N

7. Please list all medications taken, including over-the-counter, herbal or holistic remedies

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Suboxone/ Methadone,.....Y N

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   A. Local Anesthesia (Novocain, etc.).....Y N
   B. Penicillin or other antibiotics .....Y N
   C. Sedatives, Barbiturates.....Y N
   D. Aspirin or Ibuprofen.....Y N
   E. Codeine or other pain killers.....Y N
   F. Latex or Rubber Products.....Y N
   G. Eggs, Soy or Nuts.....Y N
   H. Other allergies or reactions? Please List .....Y N

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_____

9. Do you smoke or chew Tobacco.....Y N
   How much per day?_____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you .....Y N
11. Do you use marijuana or other recreational drugs.....Y N
12. Have you or any immediate family member had any problem associated with intravenous anesthesia?...Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
14. Do you wish to talk to the doctor privately about anything?.....Y N

15. FOR WOMEN ONLY
    A. Are you Pregnant or **Is there any chance you might be Pregnant?**.....Y N
    B. Are you nursing? .....Y N
    **C. If you are using Oral Contraceptives,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of the antibiotics or other medications is complete. Please consult with your physician for further guidance

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor**

_____ _____ _____
Date Signature of Person Completing Health History Doctor`s Initials

Medical Update:

Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____

Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____ Patient`s Initials _____ Date_____

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