HEALTH HISTORY

Mary M. Fisher, D.D.S & Andrea Hislop, D.D.S.

PATIENT NAME (PRINT) ____

1. WHAT IS YOUR REASON FOR TODAY'S VISIT? ____

YES / NO

2. DO YOU HAVE, OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING:
   - HEART TROUBLE, RHEUMATIC FEVER, MITRAL VALVE PROLAPSE, ARTIFICIAL HEART VALVE OR HEART MURMUR, PACEMAKER (CIRCLE)?______________________ ☐ ☐
   - RHEUMATIC FEVER? ______________________ ☐ ☐
   - SCARLET FEVER? ______________________ ☐ ☐
   - STROKE? ______________________ ☐ ☐
   - HIGH OR LOW BLOOD PRESSURE (CIRCLE)? ______________________ ☐ ☐
   - THYROID DISEASE? ______________________ ☐ ☐
   - SINUS PROBLEMS? ______________________ ☐ ☐
   - ANY SORES, UNHEALED OR INFLAMED AREAS OR GROWTHS IN OR AROUND YOUR MOUTH? ______________ ☐ ☐
   - DO YOU SMOKE, CHEW, USE TOBACCO PRODUCTS? IF SO, HOW MUCH PER DAY? ______________ ☐ ☐
   - DO YOU USE MEDICAL /RECREATIONAL MARIJUANA? IF SO, WHAT AMOUNT PER DAY? ______________ ☐ ☐
   - DO YOU HAVE ISSUES WITH HIGH OR LOW BLOOD SUGAR? DIABETES? WHAT IS YOUR RECENT HBA1C? ____ ☐ ☐
   - KIDNEY DISEASE? ARE YOU ON DIALYSIS? ______________________ ☐ ☐
   - HEPATITIS, JAUNDICE, LIVER DISEASE? ______________________ ☐ ☐
   - TUBERCULOSIS/BRONCHITIS/PNEUMONIA? ______________________ ☐ ☐
   - COUGH, PERSISTENT, BLOODY? ______________________ ☐ ☐
   - INFECTIOUS MONONUCLEOSIS? ______________________ ☐ ☐
   - SEXUALLY TRANSMITTED DISEASE? ______________________ ☐ ☐
   - AIDS, HIV POSITIVE OR POSITIVE FOR AIDS VIRUS? ______________________ ☐ ☐
   - TUMOR OR GROWTH? ______________________ ☐ ☐
   - CANCER/ RADIATION THERAPY/ CHEMOTHERAPY? ______________________ ☐ ☐
   - SPECIAL DIET? ______________________ ☐ ☐
   - GALLBLADDER TROUBLE? ______________________ ☐ ☐
   - DIET PILLS "FEN-PHEN", IONIMIN, ADIPEX, FASTIN, PONDIMIN, REDUX? ______________________ ☐ ☐
   - UNEXPLAINED WEIGHT LOSS? ______________________ ☐ ☐
   - EPILEPSY/CONVULSION? ______________________ ☐ ☐
   - ANEMIA, DISORDERS OF THE BLOOD, BLOOD TRANSFUSION? ______________________ ☐ ☐
   - BACK PROBLEMS? ______________________ ☐ ☐
   - CORTISONE TREATMENT? ______________________ ☐ ☐
   - FAINTING SPELLS, DIZZINESS? ______________________ ☐ ☐
   - SWOLLEN NECK GLANDS? ______________________ ☐ ☐
   - DIFFICULTY SWALLOWING? ______________________ ☐ ☐
   - ARTIFICIAL/PROSTHETIC JOINTS OR IMPLANTS? ______________________ ☐ ☐
   - LUNG DISEASES? CIRCLE: DIFFICULTY BREATHING, ASTHMA, BRONCHITIS, EMPHYSEMA, COPD?__________ ☐ ☐
   - DO YOU HAVE DELAYED HEALING? ______________________ ☐ ☐
   - IMMUNE SYSTEM PROBLEMS, POSSIBLY FROM SURGERY/MEDICATIONS? ______________________ ☐ ☐
   - ARTHRITIS: OSTEO OR RHEUMATOID? SWOLLEN ANKLES? ______________________ ☐ ☐
   - GLAUCOMA/EYE DISEASE? ______________________ ☐ ☐
   - DO YOU WEAR CONTACTS? ______________________ ☐ ☐
   - ACID REFLUX/GI ISUES/COLITIS/IBS/GERD/ULCER? (CIRCLE)______________________ ☐ ☐
3. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE:
   - TMJ/TMD (TEMPOROMANDIBULAR JOINT DISORDER) OR CLICKING OF JAW? ______________________ ☐ ☐
   - DIFFICULTY OPENING OR MUSCLE SPASMS OF THE JAW? ______________________ ☐ ☐
   - HEADACHES, SORE MUSCLES OF HEAD/NECK UPON WAKING/OTHER? ______________________ ☐ ☐
   - DIFFICULTY BREATHING THROUGH NOSE? SLEEP APNEA, CPAP MACHINE? ______________________ ☐ ☐

- ANY PROLONGED BLEEDING FROM AN INJURY, TOOTH EXTRACTION, ETC.? DO YOU BRUISE EASILY? __________ ☐ ☐
- HAVE YOU EVER HAD A REACTION FROM A LOCAL ANESTHETIC? __________ ☐ ☐
- HAVE YOU EXPERIENCED ANY ILLNESS OR COMPLICATIONS FOLLOWING DENTAL TREATMENT OF ANY KIND?__ ☐ ☐
  IF YES, PLEASE EXPLAIN:

  ____

4. HAVE YOU TAKEN MEDICATION (PILLS) OR RECEIVED IV INFUSION FOR BONE HEALTH OR TO TREAT OR PREVENT OSTEOPENIA/OSTEOPOROSIS, SUCH AS [CIRCLE]: XGEVA PROLIA RECLAST FOSAMAX ACTONEL BONIVA ZOMETA AREDIA OR OTHER BISPHOSPHONATES? __________ ☐ ☐
5. OSTEONECROSIS? __________ ☐ ☐
6. DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY/DRUG ABUSE? __________ ☐ ☐
7. DO YOU HAVE A HISTORY OF ALCOHOL DEPENDENCY? __________ ☐ ☐
8. HAVE YOU HAD ANY ILLNESS/OPERATION/HOSPITALIZED IN THE LAST 5 YEARS? __________ ☐ ☐
9. ANY MENTAL HEALTH PROBLEMS /ANXIETY/ DEPRESSION? __________ ☐ ☐
10. DO YOU FEEL SAFE AT HOME? __________ ☐ ☐
11. ARE YOU BEING PHYSICALLY AND/OR SEXUALLY ASSAULTED AT HOME? __________ ☐ ☐
12. DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? __________ ☐ ☐
13. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

    ____

WOMEN:

14. ARE YOU PREGNANT OR NURSING? __________ ☐ ☐
15. ARE YOU TAKING BIRTH CONTROL? __________ ☐ ☐

ALLERGIC TO ANY DRUGS, MEDICATIONS, ETC.?

	YES	NO	NOTES/REACTION
LOCAL ANESTHETIC			
PENICILLIN			
AMOXICILLIN			
OTHER ANTIBIOTICS			
SULFITES			
SULFA DRUGS			
ASPIRIN			
LATEX			
OTHER (LIST):			

LIST ALL MEDICATIONS/SUPPLEMENTS:

MEDICATION	DOSE	FREQUENCY	NOTES

PATIENT SIGNATURE __________ DATE __________

DOCTOR SIGNATURE __________ DATE __________