General Health History

Name ____________________

Name of physician ____________________

Reason for last physician's visit ____________________

Drugs or medications currently taking ____________________

Are you sensitive or allergic to any drugs? If so, list ____________________

Have you been hospitalized in the last two years? If so, explain ____________________

Do you now have, or have you had, any of the following?

A.I.D.S. / H.I.V. Pos.	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Artificial Joint (Hip, Knee)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Asthma or Hay Fever	☐ Yes	☐ No	Long-Term Steroid Use	☐ Yes	☐ No
Blood Diseases	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatism or Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Fainting Spells or Seizures	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Are you sensitive or allergic to Latex?	☐ Yes	☐ No

Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No

If so, explain ____________________

Do you now take, or have you ever taken, any of the following drugs? (Check all that apply)

☐ Bisphosphonates ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Aredia ☐ Zometa ☐ Didronel ☐ Skelid

WOMEN: Are you pregnant? If yes, due date: ____________

Are you taking birth control pills? ☐ Yes ☐ No

Do you use tobacco products (either smoking or chewing)? ☐ Yes ☐ No

If yes, for how long? ____________________

Dental History

Dental complaint at this moment ____________________

How long has this condition persisted? ____________________

Is there anything about your teeth you'd like to change? ____________________

Date of your last dental treatment _____/_____/_____ Date of Last Cleaning _____/_____/_____

Do you grind or clench your teeth?	☐ Yes	☐ No	Do your gums bleed?	☐ Yes	☐ No
Pain in jaw joint?	☐ Yes	☐ No	Cold or canker sores?	☐ Yes	☐ No
Sore or sensitive teeth?	☐ Yes	☐ No	Unpleasant taste?	☐ Yes	☐ No

In case of emergency, contact: ____________________ Telephone ____________

Permission to release info to ____________________

Relationship to patient ____________________

I certify the above information is true, and I will notify you of any changes.

Signature ____________________ Date _____/_____/_____

Signature ____________________ Date _____/_____/_____

Signature ____________________ Date _____/_____/_____

Signature ____________________ Date _____/_____/_____