

Health History

Intake Vitals	
Blood Pressure:	_____ / _____ mmHg
Pulse:	_____ bpm
SpO ₂ :	_____ %



Patient Name: _____ Gender: _____ Height: _____ Weight: _____

1. Please list all past and present medical conditions and years diagnosed (additional space on back of form): _____

2. Who is your physician? _____ Phone: _____

Who is your dentist? _____ Phone: _____

3. Have you ever been hospitalized? Yes No

If yes, please list illness and year: _____

4. Do you have or have had any of the following conditions?

Heart Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	High or Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation or Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever following anesthesia or exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bloody Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prosthetic Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots in the legs or lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No		

5. Are you currently taking any drugs or medications? Yes No

If yes, please list (additional space on back of form): _____

6. Are you allergic or sensitive to any medications or products? Yes No

If yes, please list (additional space on back of form): _____

7. Do you have a history of breast, bone, prostate, lung, or metastatic cancer? Yes No

8. Have you ever received injection-based bone strengthening medicine (Reclast/Prolia/Xgeva/Zometa)? Yes No

9. Have you ever taken oral bisphosphonates? Yes No

10. Are you being treated for osteoporosis? Yes No

11. Do you bleed excessively when injured or after surgery? Yes No

12. Are you subject to fainting, lightheadedness, or anxiety while receiving medical care? Yes No

13. Do you snore or have you ever received a diagnosis of sleep apnea? Yes No

14. Do you have difficulty breathing or have ever received a diagnosis of asthma, COPD, tuberculosis, etc? Yes No

15. Have you ever had an adverse reaction to dental local anesthetic? Yes No

16. Do you or your genetic family have any known relatives who have been diagnosed with malignant hyperthermia? Yes No

17. Have you ever had an adverse reaction to intravenous sedation or general anesthesia? Yes No

18. Do you smoke? Yes No

If yes, what product and how often: _____

19. Have you used any recreational drugs (cocaine, methamphetamine, heroin, etc) within the past year? Yes No

If yes, which substance? (*truthful answers are lifesaving and will be kept private*) _____

For women:

20. Are you pregnant? Yes No

21. Are you currently breastfeeding? Yes No

22. Are you taking oral contraceptive pills (birth control)? Yes No

I attest that the above information is true and correct to my knowledge.

I am aware that failure to disclose accurate information places me and my health at serious risk.

Signature of Patient or Parent/Guardian: _____ Date: _____

Health History

If there was insufficient room on the previous page, please place the information below



Patient Name: _____

Medical Problems

Medications

Allergies

Other Comments