BOISE PROSTHODONTICS

HEALTH HISTORY FORM

Today's Date:

Name: **Date of Birth:**

Physician's Name: Physician's PHone:

Date of last Physician Visit: Reason:

Date of last physical examination:

PLEASE ANSWER THE FOLLOWING QUESTIONS. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

	YES	NO
1. Do we have your permission to consult with your physician?	☐	☐
2. Are you under medical treatment at this time?	☐	☐
If yes, please explain:		
3. Have you been hospitalized or had a serious illness within the last year?	☐	☐
If yes, please explain:		
4. Have you ever been advised to take antibiotics before a dental appointment?	☐	☐
If yes, please explain:		
5. Have you had any serious medical trouble associated with any dental experience?	☐	☐
If yes, please explain:		
6. Do you have any artificial joints?	☐	☐
If yes, witch joints?		
Replacement dates:		
7. Cancer?	☐	☐
If yes, Type and location?		
☐ Surgical Treatment ☐ Chemotherapy ☐ Radiation Therapy		
8. Diabetes?	☐	☐
☐ Type I ☐ Type II		
☐ Require Insulin Therapy		
Last HbA1c value?		
Date of last HbA1c?		
How often is your HbA1c tested?		
How often do you test your blood sugar?		
9. Are you taking or have you taken any BISPHOSPOHANTES? (Fosamax, Boniva, Actonel, Reclast. etc.)	☐	☐
☐ Oral ☐ IV (intravenous)		
Reason for use and how long have you used them?		

	YES	NO
10. Women only: Are you Pregnant?	☐	☐
If YES, expected delivery date?		
Are you Nursing?	☐	☐
Are you going or have gone through menopause?	☐	☐
10. Do you currently use tobacco	☐	☐

☐ Cigarettes ☐ Snuff/Ches ☐ Cigar ☐ Pipe

How much per day? _____ Years of use? _____

11. Do you have a past history of tobacco use?	☐	☐

When did you quit? _____

DO YOU HAVE OR HAVE YOU HA ANY OF THE FOLLOWING? Please check the boxes that apply.

- ☐ Artificial Joint Replacement
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Angina Pectoris (Chest Pain)
- ☐ Arterio/Atherosclerosis
- ☐ Pace Maker
- ☐ Rheumatic Fever/Rheumatic Heart Disease
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Transfusion
- ☐ Abnormal Bleeding/Blood Disorder
- ☐ Positive HIV, AIDS, AIDS Complex
- ☐ Tuberculosis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Stroke
- ☐ Asthma
- ☐ Emphsema
- ☐ COPD
- ☐ Acid Reflux/GERD
- ☐ Hay Fever
- ☐ Lung Disease
- ☐ Sinus Problems
- ☐ Glaucoma/Impaired Eyesight
- ☐ Kidney Condition: Shunt/Dialysis
- ☐ Autoimmune Disorder
- ☐ Arthritis
- ☐ Allergies
- ☐ Cortisone Therapy
- ☐ Depression
- ☐ Anxiety
- ☐ Recreational Drug Usage
- ☐ Alcohol Addition
- ☐ Epilepsy/Seizures
- ☐ Liver Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Organ Transplant
- ☐ Parkinson's Disease
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Jaw Joint Pain
- ☐ Frequent Headaches/Migraines

If yes to any of the above conditions, please explain.

ALLERGIES Are you allergic to any of the following conditions?

- ☐ Aspirin
- ☐ Jewerly
- ☐ Tetracycline
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa
- ☐ Dental Anesthetic
- ☐ Metals
- ☐ Barbiturates
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Tranquilizers

Other?

	YES	NO
Have you ever had an adverse reaction (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any medications?	☐	☐

If yes, please explain

LIST ANY MEDICATIONS YOU ARE TAKING (INCLUDING NON-PRECRIPTION, HERBAL, VITAMINS AND SUPPLEMENTS)

Medication	Dosage	Reason for Taking

If you have any medical problem/ condition not listed you feel we should know about, please explain here.

Signature

Print Form