Health History Form

Name:_____ Date:_____ DOB:_____ Height:_____ WT:_____

Circle Yes or No and fill in where applicable

Do you have or have you ever had any of the following:

Heart problems	Y N	Arthritis	Y N	Drug abuse	Y N
Chest pain	Y N	Stomach ulcers	Y N	Alcohol abuse	Y N
Chest tightness	Y N	Knee replacement	Y N	Depression	Y N
Heart surgery	Y N	If yes when?_____		Bone infection	Y N
High Blood Pressure	Y N	Hip replacement	Y N	Jaw cancer	Y N
Irregular heart beat	Y N	If yes when?_____		Mouth cancer	Y N
Heart attack	Y N	Heart valve replacement	Y N	Jaw necrosis	Y N
Fast/slow heart beat	Y N	Radiation therapy	Y N	Jaw joint pain	Y N
Stroke	Y N	Sinus problems	Y N		
Lung Problems	Y N	Cancer	Y N		
Asthma	Y N	Jaw clicking	Y N		
COPD	Y N	Jaw locking	Y N		
Emphysema	Y N	Teeth grinding	Y N		
Bronchitis	Y N	Teeh clenching	Y N		
Short of breath	Y N	Osteoporosis	Y N		
Seizures	Y N	Diabetes	Y N		
Fainting	Y N	Kidney disease	Y N		
Bleeding problems	Y N	Liver disease	Y N		
Blood disorder	Y N	Anema	Y N		
Are you pregnant	Y N	Are you nursing	Y N		
Brain/CSF shunt	Y N	Sleep apnea	Y N		

Do you use tobacco Y N
If yes, what kind and how much?_____
Do you use marijuana? Y N
If yes, how often?_____
Do you use recreational drugs such as cocaine, LSD, amphetamines, ketamine, etc….. Y N
If yes, what and how often?_____
Have you used prescription drugs such as vicodin or percocet for recreational use? Y N
If yes, which ones and how often?_____
Please list any past surgeries:_____
_____
Please list any hospitalizations:_____
_____
Have you had any problems with anesthesia? Y N
If yes, what happened:_____
Have you had any problems with prior oral surgery/jaw surgery/dental procedures: Y N
If yes, what happened:_____

By signing below, I acknowledge that I have answered all questions honestly.

Name:_____ Relation to patient:_____Date:_____