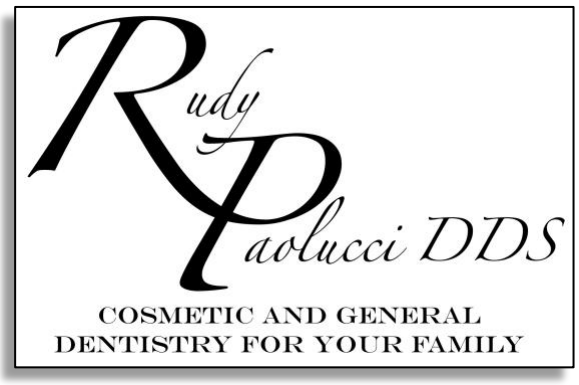
# Health History

*(Please Print Legibly)*




Patient Name: _____

Date of Birth: _____

Today's Date: _____

Updated: _____

Updated: _____

Updated: _____

## Health Information

Personal Physician
Name: _____

Preferred Pharmacy: _____

**YES NO**

❑ ❑ 1. Have you been hospitalized within the past 2 years? For what? _____

❑ ❑ 2. Are you currently being treated by a physician? For what? _____

❑ ❑ 3. Are you currently taking any medicines or drugs? List Medications: _____

_____

_____

❑ ❑ 4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?

❑ ❑ 5. Are you allergic to any drugs? What? _____

❑ ❑ 6. Have you ever had a skin rash or other reaction to metal jewelry? To What? _____

❑ ❑ 7. Are you allergic to any metals? What? _____

❑ ❑ 8. Do you bleed excessively upon injury?

❑ ❑ 9. Are you pregnant? Due Date? _____

❑ ❑ 10. Have you ever been involved with dental/medical legal activity?

❑ ❑ 11. Are you taking or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Reclast…)

❑ ❑ 9. Have you had any surgeries? When?_____

**Circle Any of the Following Conditions That You Have Had or Now Have**

| | | | |
|---|---|---|---|
| A. AIDS | G. Glaucoma | M. Kidney Problems | R. Sexually Transmitted Disease |
| B. Arthritis | H. Heart Murmur | N. Low Blood Pressure | S. Stroke |
| C. Asthma | I. Heart Problem | O. Nervous Break Down | T. Tuberculosis |
| D. Cancer | J. Hepatitis | or Psychiatric Therapy | U. Artificial Joint |
| E. Diabetes | K. High Blood Pressure | P. Osteoporosis | V. Artificial Heart Valve |
| F. Epilepsy | L. Jaundice | Q. Rheumatic Fever | W. Neurologic Disorder |

V. Other Health Concerns_____

**Person to Be Contacted in Case of Emergency**

Name: _____

Telephone: (Mobile) _____ (Home)_____

(Work) _____