Do you have or have you had any of the following? *(Please check any that apply)*

- ❑ Cancer or tumor: Type_____
- ❑ Radiation or chemotherapy
- ❑ Heart disease
- ❑ Heart murmur, heart defect (Congenital or Acquired)
- ❑ Stents
- ❑ Thyroid disorder
- ❑ Artificial joint/Replacement
- ❑ Artificial Heart Valve/Replacement
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Abnormal bleeding after extrations, surgery or trauma
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism or drug addiction
- ❑ Stroke
- ❑ Handicap/Disability
- ❑ Glaucoma or other eye disorder
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Tuberculosis
- ❑ Lung problems
- ❑ Back problems
- ❑ Organ Transplant
- ❑ Joint Problems
- ❑ Anemia or Blood Disorders
- ❑ Angina
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Trauma to the Head/Neck/Face
- ❑ Hayfever or sinus trouble
- ❑ Allergies, hives or anaphylaxis
- ❑ Asthma
- ❑ Cortisone medicine
- ❑ Other_____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate (bone building) medications? ❑ yes ❑ no

Women: ❑ May be pregnant Expected delivery date:_____ ❑ Taking hormones or contraceptives ❑ Nursing

Have you ever been hospitalized or had surgery? ❑ yes ❑ no
If yes, please explain:_____

Known allergies:_____

_____

_____

Please list medications and reasons for taking:

_____

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I will inform the dental office of any changes in medical status.

Signature of patient (or parent)_____Date_____

Health History Changes

(FOR OFFICE USE ONLY)

Date	Change	Patient Initial