

# HEALTH HISTORY

Since your well-being is our primary concern, please take the time to accurately answer the questions.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Date: \_\_\_\_\_

\* Reason for visit: \_\_\_\_\_

\* Your **current physical health** is: Good / Fair / Poor Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

\* Are you currently under the care of a physician? Yes / No Date of last visit/reason: \_\_\_\_\_

If Yes for what: \_\_\_\_\_

\* Do you have any **allergies**? Yes / No List: \_\_\_\_\_

\*Are you allergic to (**please circle**): Penicillin, Sulfa, Clindamycin, Tetracycline, Codeine, Morphine, Ibuprofen, Aspirin, Iodine, Tape, Latex, Shellfish, Eggs or Soy

\* Do you have an **Advance Directive**? Yes/No

\* Have you ever had any problems with **Local Anesthesia**? Yes / No Type of Reaction: \_\_\_\_\_

\* Have you ever had any problems with **General Anesthesia**? Yes / No Type of Reaction: \_\_\_\_\_

\* Do you or a family member have any history of **Malignant Hyperthermia** (life threatening reaction to general anesthesia)? Yes / No

\* Are you taking any **medications, drugs, or pills** (birth control / **inhalers** / aspirin / nitroglycerin / blood thinners / vitamins / **Herbs**)? Yes / No List: \_\_\_\_\_

\* Have you ever taken **cortisone / prednisone** or other **steroid** drugs longer than 2 weeks? Yes / No

\* Have you ever or are you currently taking **bisphosphonate** medication for osteoporosis or cancer treatment? Yes / No

\* Have you ever taken **Accutane**? Yes / No

\* Have you had any **Operations** or been **Hospitalized**? Yes / No List: \_\_\_\_\_

\* **Have you had or do you currently have any of the following? (Circle Yes or No for each one)**

- |  |                                      |                                  |                                   |
|--|--------------------------------------|----------------------------------|-----------------------------------|
| Y / N Recent Weight Loss                   | Y / N Glaucoma                       | Y / N <b>Irregular Heartbeat</b> | Y / N <b>Diabetes</b>             |
| Y / N Dieting (Pills Y / N)                | Y / N Hearing Problems               | Y / N <b>Pacemaker/ ICD</b>      | Y / N Thyroid Problems            |
| Y / N Angioedema<br>(spontaneous swelling) | Y / N Nasal Congestion               | Y / N Heart Surgery              | Y / N <b>Blood Clots</b>          |
| Y / N Vitiligo (loss skin pigment)         | Y / N Nose Bleeds                    | Y / N Circulation Problems       | Y / N <b>Abnormal Bleeding</b>    |
| Y / N Acne                                 | Y / N Cold Sores / Fever Blisters    | Y / N High Blood Pressure        | Y / N Bruise Easily               |
| Y / N <b>Radiation Treatment</b>           | Y / N Bronchitis                     | Y / N Low Blood Pressure         | Y / N Anemia                      |
| Y / N <b>Chemotherapy</b>                  | Y / N <b>Asthma</b>                  | Y / N Heartburn / Reflux         | Y / N Sickle Cell                 |
| Y / N Dizziness                            | Y / N Difficulty Breathing           | Y / N Ulcer                      | Y / N Porphyria                   |
| Y / N Fainting                             | Y / N Snoring                        | Y / N Pancreatitis               | Y / N Blood Transfusion           |
| Y / N Frequent Headaches                   | Y / N Sleep Apnea                    | Y / N Liver Disease/Hepatitis    | Y / N Cancer                      |
| Y / N Hay Fever                            | Y / N Emphysema / COPD               | Y / N Bladder Problem            | Y / N Tumor                       |
| Y / N Sinus Problems                       | Y / N Tuberculosis                   | Y / N Kidney Disease             | Y / N <b>HIV + / AIDS / ARC</b>   |
| Y / N <b>Popping/Clicking Jaw Joint</b>    | Y / N <b>Chest Pain / Angina</b>     | Y / N Dialysis                   | Y / N STD                         |
| Y / N <b>TMJ Pain (Jaw Joint Pain)</b>     | Y / N Heart Attack                   | Y / N Organ Transplants          | Y / N Seizures                    |
| Y / N Clenching/Grinding Teeth             | Y / N <b>Heart Murmur</b>            | Y / N Arthritis                  | Y / N Stroke                      |
| Y / N Use Night/Bite Guard                 | Y / N <b>Artificial Heart Valves</b> | Y / N Back Pain/Sciatica         | Y / N <b>Numbness</b>             |
| Y / N Contact Lenses/Glasses               | Y / N Rheumatic Fever                | Y / N Fibromyalgia               | Y / N <b>Artificial Joints</b>    |
|  | Y / N Heart Failure                  | Y / N Osteoporosis/Osteopenia    | Y / N Depression / Anxiety        |
|  |                                      |                                  | Y / N Other Psychiatric Illnesses |

**Are there any conditions / problems not listed above you think the doctor should know about?** Yes / No List: \_\_\_\_\_

\* Do you now or did you ever use **tobacco**? Yes / No ( Chew / Smoke ) Packs per day: \_\_\_\_\_ Years: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

\* Do you now or did you ever drink **alcohol**? Yes / No Amount: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

\* Do you now or did you ever use **marijuana**? Yes / No (Edible / Smoke) Frequency per day: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

\* Do you now or did you ever use **recreational drugs**? Yes / No Type: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

\* **Family history** of disease: (Heart Disease / Blood clots / Stroke / Angioedema / Diabetes / Vitiligo / Skin Cancer / Cancer)? Yes / No List: \_\_\_\_\_

\* **Women** - Are you or could you be **pregnant**? Yes / No Last Period Date? \_\_\_\_\_ Are you **nursing**? Yes / No

\* **Men** - Difficult urinating? Yes / No Enlarged prostate? Yes / No

**I hereby certify that the answers I have given to the above questions are true & correct to the best of my knowledge. I will not hold my surgeon, or any member of their staff, responsible for any errors or omissions that I may have made in the completion of this form.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

Updated \_\_\_\_\_ Signature \_\_\_\_\_