PATIENT HEALTH HISTORY

HOSPITAL ADMISSIONS IN THE LAST 5 YEARS

INDICATE THE YEAR YOU WERE ADMITTED TO HOSPITAL AND THE REASON. DO NOT INCLUDE NORMAL PREGNANCIES.

DATE	ILLNESS OR OPERATION	DATE	ILLNESS OR OPERATION

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING, INCLUDE OVER-THE-COUNTER Rx, CHEMOTHERAPY, IRRADIATION

NAME	DOSAGE	HOW OFTEN		NAME	DOSAGE	HOW OFTEN

Have you ever taken (Orally or Injection) any bone strengthening drugs (Bisphosphonates- Prolia, Zometa, Xgeva)? **Yes** or **NO**

DRUG ALLERGIES:_____

MEDICAL DOCTOR:_____ PHONE:_____LAST EXAM:_____

FORMER DENTIST:_____LAST EXAM:_____

DIAGNOSES/CONDITIONS

MARK "**C**" FOR CURRENT PROBLEMS, CHECK BOX AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING:

CARDIOVASCULAR
- □RHEUMATIC FEVER
- □BIRTH HEART DEFECTS
- □CORONARY ARTERY DISEASE
- □STROKE
- □ARTERIOSCLEROSIS
- □HIGH BLOOD PRESSURE
- □PACEMAKER
- □SIGNIFICANT HEART MURMUR
- □ARTIFICIAL HEART VALVE
- □BLOOD TRANSFUSION
- □ANEMIA
- □LEUKEMIA
- □HEMOPHILIA
- □PURPURA
- □CONGESTIVE HEART FAILURE

RESPIRATORY
- □EMPHYSEMA
- □BRONCHITIS
- □PNEUMONIA
- □ASTHMA/HAY FEVER
- □PERSISTENT COUGH

INFECTIONS
- □HEPATITIS
- □HIV
- □HERPES
- □TUBERCULOSIS
- □VENEREAL DISEASE

SYSTEMIC
- □CANCER (TYPE:_____)
- □KIDNEY DISEASE
- □PROSTATE PROBLEMS
- □BENIGN TUMORS
- □PEPTIC ULCER
- □HIATAL HERNIA
- □FREQUENT VOMITING/INDIGESTION
- □LUPUS/SCLERODERMA
- □COLITIS
- □ADRENAL INSUFFICIENCY
- □DIABETES
- □HYPERTHYROIDISM
- □HYPOTHYROIDISM
- □SKIN DISEASE
- □METABOLIC NUTRITIONAL DISORDER
- □UNRESTFUL SLEEP

MUSCULOSKELETAL & NEURAL
- □OSTEOPOROSIS
- □OSTEOARTHRITIS
- □RHEUMATOID ARTHRITIS
- □GOUT
- □ARTIFICIAL JOINTS
- □PARALYSIS
- □CHRONIC PAIN
- □SEIZURES
- □NUMBNESS
- □DEPRESSION
- □RETARDATION

DENTOFACIAL
- □GLAUCOMA
- □CATARACT
- □SORE EYES
- □FREQUENT HEADACHES
- □SINUSITIS
- □FREQUENT NOSEBLEEDS
- □EAR PROBLEMS
- □FREQUENT SORE THROAT
- □SMOKING
- □CLENCH OR GRIND TEETH
- □SNORE EXCESSIVELY
- □SLEEP APNEA
- □BLEEDING GUMS
- □BAD BREATH/TASTE
- □CROOKED TEETH, BAD BITE
- □DISCOLORED OR DEFORMED TEETH
- □MISSING, LOOSE, DRIFTING TEETH
- □SENSITIVE TEETH, RECEDING GUMS
- □FREQUENT SORES ON LIPS OR GUMS
- □DIFFICULTY CHEWING FOOD
- □FREQUENT CHOKING
- □OTHER:_____

WOMEN:
- □CURRENTLY PREGNANT
- □REGULAR MENSTRUAL PERIODS
- □BIRTH CONTROL
- □HORMONE REPLACEMENT

OTHER MEDICAL OR DENTAL CONDITIONS?_____

WHAT ADVERSE DENTAL EXPERIENCES, IF ANY, HAVE YOU HAD IN THE PAST?_____

_____

HOW IMPORTANT IS YOUR DENTAL HEALTH AND APPEARANCE TO YOU? _____

_____

IF YOU COULD MAKE ANY CHANGES YOU WANTED TO YOUR SMILE, WHAT WOULD THOSE CHANGES BE? _____

_____

WOULD YOU LIKE INFORMATION FROM OR A REFERRAL TO A FACIAL PLASTIC SURGEON FOR EVALUATION? _____

SIGNATURE:_____DATE:_____