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