HEALTH HISTORY

Who referred you? ______________________________ Reason for your visit? ____

Physician Name: ____________________________________ City: _____________________________ Phone: __________________

Date of last physical exam: _________ Pharmacy Name: _______________________ ZIP: ___________ Phone: _________________

Dentist Name: _______________________________________ City: _____________________________ Phone: _________________

Date of last dental exam: ______________ Date of last dental hygiene visit: ____________ Date of last dental x-rays: ______________

List medications (including birth control), vitamins, supplements, recreational drugs you are taking (no doses, only names):

____

____

Allergies & adverse reactions: ____

Issues with prior surgery, anesthesia, or dental treatment:

____

____

WHICH OF THE FOLLOWING PERTAIN TO YOU?

Premedication	Yes	No	A condition requiring delay of care	Yes	No
Diet drugs (e.g., FenPhen)	Yes	No	Respiratory issues	Yes	No
Kidney disease / stones	Yes	No	Hearing issues / aids	Yes	No
Mental disorder	Yes	No	Tuberculosis	Yes	No
Venereal disease	Yes	No	Excessive bleeding / bruise easily	Yes	No
Hives or rash	Yes	No	Glaucoma	Yes	No
Rheumatic fever	Yes	No	Blood disorder	Yes	No
Rheumatism	Yes	No	Intellectual disorder	Yes	No
Asthma / respiratory issues	Yes	No	Developmental disorder	Yes	No
Heart issues	Yes	No	Radiation treatment / chemo	Yes	No
Autoimmune disorder	Yes	No	Cancer	Yes	No
High blood pressure	Yes	No	Thyroid issues	Yes	No
Stroke	Yes	No	GI issues	Yes	No
Prosthetic joints or devices	Yes	No	Head injury / surgery	Yes	No
Shortness of breath	Yes	No	Gender affirming process	Yes	No
Communicable disease	Yes	No	Diabetes (HbA1c _______)	Yes	No
Hepatitis / jaundice / liver disease	Yes	No	Seizures / epilepsy / fainting	Yes	No
Arthritis / joint pain	Yes	No	Substance abuse	Yes	No
Current pregnancy / nursing (____ months)	Yes	No	Sudden weight gain / loss	Yes	No
Osteoporosis / history of bisphosphonates	Yes	No	Ulcers / chronic canker sores	Yes	No
Sleep study / poor sleep	Yes	No	Nervous disorder	Yes	No
COVID vaccination (Dose #___)	Yes	No			

Serious illness / operation / hospitalization within the last 5 years? ………………………………………. Yes No

Other health issues or elaboration of items from above: ____

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If completing this form for another person, Name: _____________________________ Street: _____________________________

City: ___________________________________ ZIP: _________ Phone: ____________________ Relationship: __________________

Signature: ____ **Date:** ____________________