



**John-Michael Stewart**

DENTAL IMPLANTS & ORAL SURGERY

## HEALTH HISTORY FORM

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Today's Date \_\_\_\_\_

**An accurate and complete health history will assist in coordinating your dental care.  
Please speak with the doctor or staff if there are any questions about this form.**

Are you now under a doctor's care for a medical condition? (circle one) Yes/No

Name condition/s : \_\_\_\_\_

Do you require a medical clearance from your health care team? Yes/ No

Name condition needing medical clearance: \_\_\_\_\_

Do you have to **premedicate** prior to having any surgery? (circle one) Yes/No

Name of physician / Specialist \_\_\_\_\_

Physician/ Specialist phone number \_\_\_\_\_

Physician / Specialist fax number \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

Have you ever been hospitalized or had a serious illness? (circle one) Yes/No

If yes, please

describe \_\_\_\_\_

Have you ever had surgery? (circle one) Yes/No

If yes, please

describe \_\_\_\_\_



HEALTH HISTORY FORM

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions (circle yes or no and IF YES, PLEASE CIRCLE ALL THAT APPLY IF THERE ARE MULTIPLE CHOICES):

Heart Disease Yes/ No

Congenital heart disease, cardiovascular disease heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker

Lung disease Yes/ No

asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing

Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee? Yes / No

Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? Yes / No

Kidney disease or kidney failure, requiring dialysis? Yes / No

Liver disease – like jaundice, hepatitis A, B, or C? Yes / No

Thyroid disease? Yes / No

Arthritis? Yes / No

Stomach ulcers or colitis? Yes / No

Significant weight loss or gain? Yes / No

Diabetes? Yes / No

Sinus or nasal problems? Yes / No

Sleep apnea? Yes / No

Cancer? (If yes to cancer, please fill out below):

If yes, type \_\_\_\_\_

Diagnosis date \_\_\_\_\_

Treatments \_\_\_\_\_

Do you have any other medical conditions that are important for your doctor to know about? (circle one) Yes / No If yes, please describe \_\_\_\_\_

MEDICATIONS – Are you currently taking any of the following? (circle yes or no) – IF YOU ANSWER YES TO BIRTH CONTROL, LIST THE NAME OF IT; OTHERWISE, ALL OTHER MEDICATIONS ARE TO BE LISTED ON THE NEXT PAGE.

Blood pressure medications? Yes/No

Antibiotics? Yes/No

Prescription pain medication? Yes/No

Anticoagulants or blood thinners? Yes/No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes/No

Heart medications? Yes /No

Steroids – like cortisone or prednisone? Yes/No

Weight LOSS medication- Yes/No

If yes; when was the last dose? \_\_\_\_\_

Anti-anxiety agents, antidepressants, or other psychiatric medications? Yes / No

Birth control medication? Yes/No

If yes, print name of birth control medication

\_\_\_\_\_ Bisphosphonates or other medications to strengthen your bones? Yes/ No

Etidronate (Didronel)

Tiludronate (Skelid) .

Alendronate (Fosamax)

Risedronate (Actonel)

Ibandronate ( Soniva)

Zoledronate (Zometa)

Cancer or chemotherapy drugs? Yes/ No

Insulin or oral anti-diabetic drugs? Yes/No



**ALLERGIES** – Are you allergic to or have you had an adverse reaction to (**circle yes or no and list allergies**):

Latex? Yes / No

Codeine or other pain control medications? Yes / No

Food or food products? Yes / No

Aspirin, ibuprofen (Motrin), or naproxen (Aleve)? Yes / No

Sedatives or barbiturates? Yes / No

Penicillin or other antibiotics? Yes / No

Any other medications? Yes / No

Any other allergies? Yes / No

If yes, please describe \_\_\_\_\_

**ANESTHESIA HISTORY**

Have you had any problem associated with local or general anesthesia and/or intravenous sedation?

Yes / No

If yes, please describe \_\_\_\_\_

**FEMALE PATIENTS**

Are you pregnant? Yes / No

Is there any chance you might be pregnant? Yes / No

**SOCIAL HISTORY (circle yes or no)**

Do you currently smoke, vape or chew tobacco?

Yes / No If yes, for how long?  
\_\_\_\_\_

Have you ever smoked, vaped or chewed tobacco?

Yes / No If yes, for how long?  
\_\_\_\_\_

Have you ever sought professional care or been hospitalized for:

Substance abuse Yes / No

Emotional disorders Yes / No

Alcoholism Yes / No

Do you use:

Alcohol? Yes / No

If yes, how often per week? \_\_\_\_\_

Marijuana? Yes / No

If yes, how often per week? \_\_\_\_\_

Recreational drugs? Yes / No

If yes, how often per week? \_\_\_\_\_



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**MEDICATIONS (continued): Please list the specific medications in the APPROPRIATE COLUMNS (if you are providing a separate list of medications, please indicate which are over-the-counter by writing OTC next to it)**

PRESCRIPTION medication and dose	OVER-THE-COUNTER medication, herbal or holistic remedies, vitamins or minerals



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**DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE?** (circle one) Yes / No

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**I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.**

\_\_\_\_\_  
Printed name of patient, parent, guardian/Relationship

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Signature of patient, parent, guardian/Relationship

\_\_\_\_\_  
Today's Date

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**For office staff use - HEALTH HISTORY REVIEW**

Comments/Doctor's Signature

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