**Provider: Dr Ash**

# Health History Form

Name: _____ Date of Birth: _____
Last First Middle (MM/DD/YYYY)

All information provided here is **confidential** and any attempt to conceal pre -existing conditions or other relevant information may result in serious drug interactions or death. For the following questions**, please circle Yes or No:**

1. Are You in Good Health? ..... Yes No
- Has There Been Any Change in Your General Health Within the Past Year?..... Yes No
3. My Last Physical Exam Was On: _____
4. Are You Now Under the Care of a Physician? ..... Yes No
   If Yes, For What Condition? _____
5. Your Physician's Name: _____
   Your Physician's Phone #: _____
6. Do You Smoke? ..... Yes No
   If So, How Many Packs/Day_____ Years_____
7. Have You Had Any Serious Illness, Operation, or Been Hospitalized in The Past 5 Years..... Yes No
8. Are You Taking Any Medicine(s), Including Non-Prescription Medicines? ..... Yes No
9. Have You Ever Taken Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zoledronate (Reclast), Pamidronate (Aredia), Denosumab (Prolia), Bevacizumab (Avastin), Sunitinib (Sutent) **(circle which one)**? ..... Yes No
10. Do You Have or Have You Had Any of The Following Diseases?
    a. Damaged or Artificial Heart Valves, Heart Murmur, or Rheumatic Heart Disease **(circle which one)** ..... Yes No
    b. Artificial Joints or Prostheses..... Yes No
       If Yes, Where? _____
    c. Cardiovascular Disease, Angina, Heart Attack, Heart Trouble, Coronary Bypass Operation, Stroke **(circle which one)** ..... Yes No
    d. Do You Have A Pacemaker? ..... Yes No
    e. High Blood Pressure..... Yes No
    f. High Cholesterol ..... Yes No
    g. Diabetes (Blood Sugar Problems) ..... Yes No
    h. Osteoporosis..... Yes No
    i. Tumor or Cancer Requiring Surgery, Radiation or Chemotherapy **(circle which one)** ..... Yes No
    j. Fainting Spells, Seizures or Epilepsy **(circle which one)** ..... Yes No
    k. Phobias, Sever Anxiety, Depression **(circle which one)** ..... Yes No
    l. Thyroid Problems ..... Yes No
    m. Sinus Problems..... Yes No
    n. Ear or Hearing Problems **(circle which one)** ..... Yes No
    o. Arthritis, Rheumatism **(circle which one)** ..... Yes No
    p. Kidney Disease..... Yes No
    q. Hepatitis, Jaundice or Liver disease **(circle which one)** ..... Yes No
    r. AIDS or HIV+ Infection..... Yes No
    s. Tuberculosis (TB)..... Yes No
    t. Sexually Transmitted Disease..... Yes No
    u. Sleep Apnea..... Yes No
    v. Asthma or Emphysema **(circle which one)** ..... Yes No
    w. Respiratory Problems, Bronchitis **(circle which one)** ..... Yes No
    x. Stomach Ulcer, Hyperacidity, GERD **(circle which one)** ..... Yes No
    y. Cortisone Treatment..... Yes No
    z. Glaucoma..... Yes No
11. Have You Had Abnormal Bleeding.?..... Yes No
    or Required A Blood Transfusion? ..... Yes No
12. Do You Have Any Blood Disorder Such as Anemia? ..... Yes No
13. Are You Allergic or Have You Had A Reaction To:
    a. Dental Anesthetics..... Yes No
    b. Penicillin or Other Antibiotics **(circle which one)** ..... Yes No
    c. Sulfa Drugs ..... Yes No
    d. Barbiturates, Sedatives or Sleeping Pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or Other Narcotics **(circle which one)** ..... Yes No
    h. Latex ..... Yes No
    i. Other _____
14. Have You or A Close Relative Ever Had an Anesthesia Complication? Or a Bad Reaction to Anesthetic Drugs? ..... Yes No

**Women**

15. Are You Pregnant? ..... Yes No
16. Are You Nursing?..... Yes No
17. Are You Taking Birth Control Pills?..... Yes No

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and or dental status to my periodontist at the earliest possible time. I give permission to my periodontist to obtain any additional information from my physician regarding my medical history.

_____

Patient's Signature (or patient's guardian) Date

_____

Ash, DDS, MS Date

**Provider: Dr Ash**

# Medication list

**Patient Name: _____** **Date: _____**

| Name of Medicine(s), Over the Counter Medicine(s), Herbal Medicine(s), Vitamin(s), or Street Drugs | Dosage (mg) | How Often is it Taken | Disease Being Treated or Reason for Taking | Prescribing Doctor or Self Prescribed |
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