Providence
Oral Surgery & Dental Implant Center

Health History Form

Patient's Name _____ **Date of Birth** _____/_____/_____

Gender: M / F Height: _____ Weight: _____ SSN: _____

Address: _____ City: _____ State:_____ Zip: _____
Email address: _____

Cell phone number (_____)_____-_____ Home phone number: (_____)_____-_____

Emergency contact: (_____)_____-_____ Name/Relationship to patient: _____
General Dentist: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

MEDICAL HISTORY

Heart problems such as: heart attack, stents placed, coronary artery disease, heart failure, A-fib, arrhythmia?	Yes No	Lung disease such as: asthma, COPD, emphysema, bronchitis?	Yes No
Do you have chest pain or shortness of breath?	Yes No	Excessive bleeding, bleeding disorder, easy bruising?	Yes No
Any implanted devices such as a pacemaker or hip/knee replacement?	Yes No	Liver disease (including hepatitis)?	Yes No
High blood pressure?	Yes No	Arthritis (osteoarthritis or rheumatoid arthritis)?	Yes No
Stomach ulcers or gastritis?	Yes No	Seizures, fainting, or epilepsy?	Yes No
Thyroid disease?	Yes No	Osteoporosis or osteopenia?	Yes No
Clicking, popping, or pain in the jaw joint?	Yes No	Have you ever taken a bisphosphonate such as boniva, zometa, or related medication?	Yes No
Diabetes?	Yes No	Sleep apnea? Use a CPAP?	Yes No
Any cancer, radiation, or chemotherapy?	Yes No	Sinus problems or congestion?	Yes No
Infectious disease such as HIV/AIDS?	Yes No	Any other:	

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

MEDICATIONS

Please list all the medications you currently take:

_____ _____
_____ _____
_____ _____

ALLERGIES

Please list all you medication, food, and environmental allergies and the reactions you have:

_____ / reaction: _____

_____ / reaction: _____

_____ / reaction: _____

SURGICAL HISTORY

Have you ever had surgery? Yes No

If yes, what year and what for?_____

Did you have any problems with anesthesia (for example, nausea or vomiting):

_____

FAMILY MEDICAL HISTORY

Please list any medical conditions that exist on:

Mother's side of family: _____

Father's side of family: _____

FEMALE PATIENTS

Are you pregnant or is there any chance you may be pregnant? Yes No

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SOCIAL HISTORY

Do smoke cigarettes, cigars, or vape? Yes No

If so, how much? _____

Do you drink alcohol? Yes No If so, how much? _____

Do you do any recreation drugs (example: marijuana, cocaine)? Yes No

If so, what and how much? _____ (this stays confidential, but is important for us to know for safety)

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

PATIENT/GUARDIAN SIGNATURE: _____DATE: ____/____/_____