Health History Form

Personal Information

Patient Name:_____ Date:_____
Last First Middle

Occupation:_____

Medical Information

Note: *Dr. Anderson and Dr. Moreno encourage you to answer these questions honestly and with detail. Both doctors treat all patients respectfully, and there is no judgement or prejudice. Health conditions you have can affect the health in your mouth. All information is confidential and is used only to help the doctors to propose the safest and most appropriate dental treatment plan for you.*

Medical Doctor Name:_____ Doctor Phone#:_____

Have you had any operations? If yes, please explain:_____
_____

Are you taking any Herbal Supplements? If yes, please list:_____

Have you taken bisphosphonate medications such as Fosamax, Boniva, Actonel, Atelvia, Reclast? **Yes/No**

Has your doctor told you to take antibiotics before dental work? **Yes/No**

Do you use drugs or similar substances for fun? **If yes, please list:_____**

Do you smoke/dip/chew tobacco products? **If yes, please list type:_____ How many times a day or week?_____**

Medications

Please List all of your medications or attach a page separately:
_____
_____
_____

Allergies

Please **circle and/or list** if you have allergies to any of these items below:

Latex	Sulfa Drugs	Metal
Aspirin	Seasonal Allergies	Ibuprofen/Motrin
Codeine	Sedatives/Sleeping Pills	Antibiotics: _____

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***Please list any other allergy not listed**:_____

Health Conditions

*Please circle if you **have** or **had** any of the following conditions. (If not applicable, leave blank.)*

Abnormal Bleeding Experience	Diabetes (Type 1 or Type 2)	Lupus
Acid Reflux	Fibromyalgia	Migraines
AIDS or HIV	Gastric Bypass/Sleeve	MRSA
Anemia	Glaucoma	Osteoporosis
Arthritis	Heart Disease/Attack	Sexually Transmitted Disease
Asthma	Heart Valve Replacement/Pacemaker	Sleep Apnea
Attention Deficit Disorder	Hemophilia	Stroke Date:_____
Autism	Hepatitis (Type: A, B, C)	Sudden/Frequent Bathroom Breaks
Blood Transfusion Date:_____	High Blood Pressure	Thyroid Problems
Brain/Nervous System Disorders	High Cholesterol	Tuberculosis
Breathing Problems	Jaundice	
Bulimia	Kidney Problems	Ulcers
Congenital Heart Defect	Liver Problems (cirrhosis)	

Cancer Type and Date of Diagnosis: _____ History of Chemotherapy and/or Radiation?

1. **Are You Pregnant? Yes / No If yes, when is your due date?_____**
2. **Have you ever had any artificial joint replacements? If yes, when?_____**
3. **Mental Health Diagnosis: Depression, Bipolar Disorder, Schizophrenia, Anxiety Other _____**
4. **Do you have a condition not listed above? If yes, please list: _____**

I certify that I have read and understand this form. I will not hold Alamo Springs Dental doctors or staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify my dentist of any changes in my health.

_____ **Signature of Patient/Legal Guardian**

_____ **Doctor Signature after Review**

ALAMO SPRINGS DENTAL

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Please Complete Other Side