

Patient Health History

Name _____ Date of Birth ___/___/___

Are you in good health? _____

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

Have you ever had any Bisphosphonate therapy for Osteoporosis, such as Fosamax or Boniva (if so, when)? _____

What was the name of the Bisphosphonate prescribed? _____

Have you ever had Chemotherapy? _____

When? _____ Length? _____

Name of Oncologist _____

Have you ever had a blood transfusion? _____

Do you have any drug allergies? _____

Have you ever had (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Change in Mole | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sore not healing | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Severe Headache |
| <input type="checkbox"/> Bone/Joint pain | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of hand/feet |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Cancer |

Other serious illness (specify) _____

Do you smoke? _____ How much? _____
Did you smoke? _____ How long? _____ Date Stopped __/__/__
Do you drink alcohol? _____ How much? _____
History of drug use? _____

Are you currently seeing any other physicians at this time?

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

List any current medications (include over the counter and supplements)

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes in my health or change in my medications, I will inform Dr. Astolfi at the next appointment.

Signature of patient: _____ Date: _____