House Dental
3133 E Camelback Rd #190, Phoenix, AZ 85016, USA
(602) 957 4576
www.housedental.com/

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Have you ever been hospitalized for an injury or illness?	
Have you ever had a serious head or neck injury?	
Are you taking any medications, pills, or drugs?	
Do you take, or have you taken, Phen-Fen or Redux?	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	
Are you on a special diet?	
Do you use or have you ever used tobacco?	
Do you use medical marijuana?	
Do you take any controlled substances?	
Are you pregnant or planning to become pregnant?	
Are you currently nursing?	
Taking oral contraceptives?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	

Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / osteopenia?	
Type I or Type II diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Any other medical condition we should know of?	
Is there anything else you'd like us to know about?	

Medications

Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

Doctor's signature: Date: