DR. MASSNER FAMILY DENTISTRY HEALTH HISTORY FORM

NAME_____DATE OF BIRTH_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? YES NO

DATE AND REASON_____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO

REASON_____PHYSICIAN_____

ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN PENICILLIN CODEINE METAL LATEX SULFA DRUGS (CIRCLE)
OTHER:_____

HAVE YOU EVER TAKEN AN ORAL OR IV FORM OF BISPHOSPHONATE MEDICATION

SUCH AS FOSAMAX, BONIVA, ACTONEL, ZOMETA, XGEVA, PROLIA, ETC? YES NO

DO YOU BLEED EXCESSIVELY UPON INJURY? YES NO

DO YOU SMOKE OR USE SMOKELESS TOBACCO? YES NO

WOMEN: ARE YOU: PREGNANT NURSING TAKING ORAL CONTRACEPTIVES

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE OR HAVE HAD:

AIDS/HIV POSITIVE DIABETES JAUNDICE SINUS PROBLEMS

ANXIETY DRUG ADDICTION KIDNEY ISSUES SLEEP APNEA

EPILEPSY/SEIZURES LOW BLOOD PRESSURE SNORING STROKE

ARTIFICIAL JOINT LUNG PROBLEMS HEART ISSUES:_____

CURRENT MEDICATIONS:_____

_____

SIGNATURE_____DATE_____