Patient Health History

Jeffrey L Elmer, D.D.S.

Patient Name:_____

Medical Conditions *Please check all that apply – use the Other section to describe any Conditions not listed*

- ☐ Alzheimers
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bone Density Meds
- ☐ Cancer
- ☐ Chemotherapy-Current/Past
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Dementia
- ☐ Depression/Bipolar
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Dizziness/Fainting
- ☐ Drug Hx
- ☐ Epilepsy
- ☐ Excessive Bleeding/Clotting Concerns
- ☐ Fibromyalgia/Chronic Fatigue
- ☐ Frequent Headaches
- ☐ GERD
- ☐ Hayfever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Prolapse
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis D
- ☐ Herpes Type E
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Insulin Dependent
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lowered Immune System
- ☐ Mitral Valve Prolapse
- ☐ MS
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson Disease
- ☐ Premed needed
- ☐ Radiation-Current/Past
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Sleep Problems
- ☐ Smoking
- ☐ Stents
- ☐ Thyroid Problems
- ☐ TMJ, jaw popping/clicking
- ☐ Venereal Disease

Other:_____

Allergies *Please check all that apply – use the Other section to describe any Allergies not listed*

- ☐ Acetaminophen
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Barbituates
- ☐ Sulfa

Other:_____

Current Medications *Please check all that apply – use the Addt'l Medications section to describe any Medications not listed*

- ☐ None

Addt'l Medications: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Additional Medical Questions

Are you currently under medical treatment of any kind?	☐ No	☐ Yes	
Are you now or have you ever used a bisphosphonate to treat Osteoporosis? (Actonel, Atelvia, Boniva, Fosamax)	☐ No	☐ Yes	
Have you been admitted to a hospital or needed emergency care within the last 2 years?	☐ No	☐ Yes	
Do you have any health issues or conditions that need further clarification?	☐ No	☐ Yes	

Female Patients

☐ Pregnant Due Date: _____

☐ Nursing

☐ Taking oral contraception

_____ _____

Signature Date