MOSAIC PERIODONTICS

Mosaic Periodontics
6045 S. Fashion Blvd #203, Murray Utah 84107
(801) 207-7070
www.mosaicperio.com/

HEALTH HISTORY

NAME: **| DOB:**

General Health Information

Patient Health History	
Occupation	
Are you currently under the care of a physician?	
Date of last physical exam	
Please list all hospitalizations and surgeries	
Preferred Pharmacy?	

Past and Current Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
High Blood Pressure	
High Cholesterol	
Mitral Valve Prolapse	
Heart Murmur	
Angina/Chest Pain	
Heart Attack	
Artificial Heart Valve	
Irregular/Rapid Heart Beat	
Pacemaker	
Heart Disease or bypass surgery	
Stroke	
Sleep Apnea	
Snoring/Mouth Breathing	
Asthma	
Lung Disease/Pneumonia	
Diabetes	
Thyroid Disease	
Liver disease/Hepatitis/Jaundice	
Kidney Disease/Renal Dialysis	
Osteoporosis / osteopenia	
Sinus Problems	
Headaches/Migraines	

Anemia/Abnormal Bruising or Bleeding	
Fibromyalgia/Neuropathy	
Organ Transplant	
History of cancer	
Radiation therapy	
Chemotherapy	
Epilepsy/Seizures	
Acid Reflux	
Stomach Ulcer/GERD	
Colitis	
IBS/Intestinal Problems	
Arthiritis	
Artificial Joints	
Back or Neck Pain	
Autoimmune Disease	
HIV / AIDS / STD	
Tuberculosis	
Psychiatric Treatment	
Do you have dental anxiety?	
Any other medical conditions we should know of?	

Allergies

Please check any allergies have had or currently have:	
Penicillin	
Sulfa Drugs	
Latex	
Local Anesthetics	
Aspirin	
Codeine	
Iodine	
Barbituates	
Sedatives	
Sleeping Pills	
Other Allergies:	

Medications

Please check all medications you are currently taking	
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?	

Other

Are you taking ANY OTHER medications? Including over the counter medications, vitamins, herbal supplements, eye drops and ointments	

Women Only

For Women Only	
Are you pregnant or planning to become pregnant?	
Are you breastfeeding?	
Are you taking birth control pills?	

Patient's signature: Date:

Doctor's signature: Date: