

HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? Yes No
 If yes, what is the condition being treated? _____
 Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? Yes No
 Please explain: _____
5. Are you taking any medication? Yes No
 If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? Yes No
 If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? Yes No
8. Are you sensitive or allergic to any drugs or materials? Penicillin Tetracycline Erythromycin
 Aspirin Codeine Latex Other If Other, please list: _____ Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies or Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis or Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty in Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Angina Pectoris	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N TMJ
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Ailments or Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors or Growths
<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	
10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? Cigarettes Cigars Chew Snuff Other Yes No
 If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? or Bisphosphonates? Yes No
14. Are you pregnant? If yes, how many months? N/A Yes No
15. Do you have any problems associated with your menstrual period? N/A Yes No
16. Do you take birth control pills? N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? Yes No
 Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
 Date: _____ Signature: _____
 (If patient is a minor, include printed name and signature of parent or legal guardian)

2nd **UPDATE** – Since your last visit:
 1. Have you seen a medical doctor? Yes No
 2. Have you had a change in any medication? Yes No
 3. Have you had a change in any medical condition or had surgery? Yes No
 If yes, please explain: _____
 Date: _____ Signature: _____

3rd **UPDATE** – Since your last visit:
 1. Have you seen a medical doctor? Yes No
 2. Have you had a change in any medication? Yes No
 3. Have you had a change in any medical condition or had surgery? Yes No
 If yes, please explain: _____
 Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1st	_____	____/____	_____	_____	_____
2nd	_____	____/____	_____	_____	_____
3rd	_____	____/____	_____	_____	_____