

HEALTH HISTORY

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name: _____
 Today's Date: ___/___/___ Birthdate: ___/___/___ Employer/Job Title _____
 Whom may we thank for referring you? _____
 Previous dentist's name? _____

Medical History

Do you have a personal physician? Yes No
 Physician's Name: _____
 Address: _____
City State Zip
 Phone #: () _____

Your current physical health is: Good Fair Poor
 Are you currently under the care of a physician? Yes No
 Please explain: _____

Do you smoke or use tobacco in any other form? Yes No
 If yes, how much _____ For how long _____
 Have you ever had a blood transfusion? Yes No

Are you taking any prescriptions or over-the-counter drugs? Yes No
 Drug Name/Dose _____ Reason _____
 Drug Name/Dose _____ Reason _____
 Drug Name/Dose _____ Reason _____
 Drug Name/Dose _____ Reason _____
 Drug Name/Dose _____ Reason _____

Have you experienced the following diseases or medical conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Abuse/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent/Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Persistent Cough |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis Type _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Steroid Therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis/Ulcers | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes/Fever Blisters | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes _____ | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Comment: _____

Please list any hospitalizations or major surgeries in the last five years: _____

List any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____