PATIENT HEALTH HISTORY

1. Name and address of physician ____
2. Date of last complete physical ____
3. Are you now taking any medications, drugs, or pills? ……………………………………Yes_____ No ______
   If yes, please list:____
4. Are you being treated by a physician for a specific condition? …………………………..Yes_____ No ______

   If so, please list the condition:____
5. Do you bleed excessively when cut?..Yes ____ No ______
6. Have you ever experienced a bad reaction to a dental anesthetic or any materials used in a dental office?..Yes ____No _______
7. Have you been a patient in the hospital during the past five years?...............................Yes ____No _______
8. Have you ever had a serious operation?..Yes____ No ______

   If yes, please list:____
9. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips?..Yes ____ No ______
10. Are you allergic to any medications, drugs, or pills?..Yes ____ No ______

    If yes, please list:____
11. Do you have any other allergies?...Yes ____ No ______

    If yes, please list:____
12. Do you smoke, use chewing tobacco or snuff?..Yes ____ No ______
13. Do you have or have you ever had the following:

Condition	Yes / No	Condition	Yes / No
Heart Disease	Yes ___No ___	Diabetes	Yes ___No ____
Heart Attack	Yes ___No ___	Thyroid Disease	Yes ___No ____
Angina Pectoris	Yes ___No ___	X-Ray or Cobalt Treatment	Yes ___No ____
Abnormal Blood Pressure	Yes ___No ___	Chemotherapy (Cancer, Leukemia)	Yes ___No ____
Heart Murmur	Yes ___No ___	Arthritis	Yes ___No ____
Mitral Valve Prolapse	Yes ___No ___	Glaucoma	Yes ___No ____
Rheumatic Fever	Yes ___No___	Pain in Jaw Joints	Yes ___No ____
Congenital Heart Lesions	Yes ___No ___	A.I.D.S.	Yes ___No ____
Artificial Heart Valve	Yes ___No ___	Hepatitis A (Infectious)	Yes ___No ____
Heart Pacemaker	Yes ___No ___	Hepatitis B (Serum)	Yes ___No ____
Heart Surgery	Yes ___No ___	Liver Disease	Yes ___No ____
Artificial Joints (Hip, Knee)	Yes ___No ___	Yellow Jaundice	Yes ___No ____
Anemia	Yes ___No ___	Drug Addiction	Yes ___No ____
Stroke	Yes ___No ___	Hemophilia	Yes ___No ____
Kidney Trouble	Yes ___No ___	Blood Transfusion	Yes ___No ____
Ulcers	Yes ___No ___	Venereal Disease	Yes ___No ____
Emphysema	Yes ___No ___	Cold Sores	Yes ___No ____
Tuberculosis (TB)	Yes ___No ___	Epilepsy or Seizures	Yes ___No ____
Asthma	Yes ___No ___	Psychiatric Treatment	Yes ___No ____

14. When you walk up the stairs, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are too tired?..Yes _____No _____
15. Are you on special diet?...Yes _____No _____
16. Have you lost or gained more than 10 pounds in the past year?......................................Yes _____No _____
17. Has your doctor ever said you have a tumor or cancer?...Yes _____No _____
18. Have you ever been exposed, or had a probable exposure, to A.I.D.S.?..........................Yes _____No ____
19. Do you have any disease, condition, or problem not listed?..Yes _____No ____
20. FOR WOMEN ONLY:
    Are you pregnant? ....Yes _____No ____
    If yes, what month? ______________________
    Are you taking birth control pills?…………………………………………………………………..Yes _____No ____
21. Have you taken Phen-fen or Redux?...Yes _____No____

The above information is true. If I ever have any change in my health or my medication I will inform the dentist at the next appointment.

Patient Signature____ Date _____/_____/______

Parent or Guardian _______________________________ Relations to Patient____________________________

UPDATES

Signature & Date ________________________________ Signature & Date ______________________________

Signature & Date ________________________________ Signature & Date ______________________________