

Health History

Name _____ Date _____
Name of Medical Doctor _____ Phone _____
Address _____

Estimated Date of last Physical Exam _____

Have you been under the care of a Doctor in the last 2 years? () Yes () No

Have you EVER had a serious illness or operation? () Yes () No
If yes, please explain _____

Do you smoke? () Yes () No
If yes, Pack Per Day _____

Have you EVER had excessive bleeding after a cut, injury or operation? () Yes () No

It is IMPORTANT that you report ALL drugs (Prescription & Non-prescription) and amounts you are taking since some drugs will react poorly with chemicals used in the dental office.

Have you EVER had a bad reaction to any drugs used in a dental office? () Yes () No

Are you PRESENTLY taking any drugs or medications? () Yes () No
If YES, please list _____

Have you EVER taken Bisphosphonates or drugs for Osteoporosis? () Yes () No

Are you subject to any nervous disorder, fainting, or dizziness? () Yes () No

Are you sensitive or ALLERGIC to any drugs? () Yes () No
If yes, which ones? _____

Are you ALLERGIC to any metals? () Yes () No
If yes, which ones? _____

Do you wear a pacemaker? () Yes () No

Have you had Heart Surgery? () Yes () No

Women: Are you PREGNANT? If Yes, which month? _____

Has a Physician EVER recommended that you take PRE-Medication with Antibiotics prior to dental treatment? () Yes () No

Have you EVER tested Positive for-HIV or AIDS? () Yes () No

Do you have any Prosthetic (ARTIFICIAL) Joints? () Yes () No

Are there any questions you would rather NOT answer on this form but would like to discuss in private? () Yes () No

Do you HAVE, or have you EVER had, any of the following? (circle)

Rheumatic heart disease	Respiratory problems	Scarlet Fever
Rheumatic heart fever	Sinus problems	Allergies
Anemia	Stroke	Radiation treatment
Asthma/ hayfever	Ulcers	Venereal disease
Cancer/ Tumor	TB	Diabetes
Swelling ankles/ feet	Arthritis	Glaucoma
Epilepsy	Liver disease	Head Injury
Hepatitis	Kidney disease	Blood disease
High Blood Pressure	Psychiatric treatment	Jaundice
Low Blood Pressure	Frequent headaches	Heart problems
Mitral Valve Prolapse		

Do you have any disease, condition, or problem not listed above that I should know about?

Signature _____ Date: _____