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HEALTH HISTORY

Name: _____ Date of Birth: _____/_____/_____

Physician's Name: _____

Have you been hospitalized within the past two years? Y N

Are you taking any prescription medications, drugs, or pills? Y N

If yes, please list: _____ for what condition?
_____ for what condition?
_____ for what condition?

Are you taking any blood thinners, such as coumadin, warfarin, aspirin, etc? Y N

Do you normally take antibiotics or sedatives prior to dental visits? Y N

ALLERGIES

Are you allergic, or have you had an adverse reaction to any of the following? If so, please check below:

- Antibiotics Pain Medicine Nitrus Oxide Jewelry / Metals
 Aspirin Ibuprofen Non-Steroidal Anti-Inflammatories
 Codeine Local Anesthetic Penicillin
 Other: _____

Are you allergic to any types of jewelry or metals? No Yes, please list: _____

MEDICAL HISTORY

Please check any of the following conditions which you have had, or have presently:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS or ARC | <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> Heart Disease or Surgery | <input type="checkbox"/> Neurologic Disease |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Failure/Attack | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints (Hip, Knee) | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Mitral Valve Prolapse | |

Do you have any disease, condition, or problem not listed that the doctor should know about? No Yes _____

I have none of the conditions above. Please initial: _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No Are you pregnant? Yes No If Yes, what month? _____

THE ABOVE INFORMATION IS TRUE

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Medical History Updates: Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____