Health History

Patient's Name ______________________ Sex ❒F ❒M Birth date ______________

Physician's Name ______________________ Physician's Phone ______________

Physician's Address ______________________ City __________ State ________ Zip______

Date of last physical examination ______________________

MEDICAL

Are you in good health? ❒Yes ❒No

Has there been any change in your general health within the past year? ❒Yes ❒No

Are you under the care of a physician? ❒Yes ❒No

Have you ever had any serious illness, operation, or been hospitalized? ❒Yes ❒No

Are you taking any drugs or medicine? If yes, list medication on the back. ❒Yes ❒No

Are you allergic or sensitive to any drugs? ❒Yes ❒No

Penicillin_____ Sulfa_____ Aspirin_____ Codeine or other narcotic _______ other______

Have you taken any recreational drugs in the past year (cocaine, crack, marijuana, IV drugs) ❒Yes ❒No

If yes, please list

Do you smoke? ❒Yes ❒No

Do you drink alcohol? ❒Yes ❒No

Do you have now, or have you had in the past, any of the following?

AIDS/HIV Positive ❒Yes ❒No
Anemia ❒Yes ❒No
Arthritis/Rheumatism ❒Yes ❒No
Artificial Heart Valves ❒Yes ❒No
Artificial Joints ❒Yes ❒No
Asthma ❒Yes ❒No
Back Problems ❒Yes ❒No
Excessive Bleeding ❒Yes ❒No
Blood Disease ❒Yes ❒No
Cancer ❒Yes ❒No
Chemical Dependency ❒Yes ❒No
Chemotherapy ❒Yes ❒No
Circulatory Problems ❒Yes ❒No
Congenital Heart Lesions ❒Yes ❒No
Cortisone Treatments ❒Yes ❒No
Cough, Persistent or Bloody ❒Yes ❒No
Diabetes ❒Yes ❒No
Emphysema ❒Yes ❒No
Do you wear contact lenses ❒Yes ❒No

Epilepsy ❒Yes ❒No
Fainting or dizziness ❒Yes ❒No
Glaucoma ❒Yes ❒No
Headaches or Migraines ❒Yes ❒No
Heart Murmur ❒Yes ❒No
Heart Problems ❒Yes ❒No
Hepatitis __ Type_______ ❒Yes ❒No
Herpes (cold sores) ❒Yes ❒No
High Blood Pressure ❒Yes ❒No
Jaundice ❒Yes ❒No
Jaw Pain ❒Yes ❒No
Kidney Disease ❒Yes ❒No
Liver Disease ❒Yes ❒No
Low Blood Pressure ❒Yes ❒No
Mitral Valve Prolapse ❒Yes ❒No
Nervous ❒Yes ❒No
Pacemaker ❒Yes ❒No
Prosthetic Replacement ❒Yes ❒No
Fen Phen ❒Yes ❒No

Psychiatric Care ❒Yes ❒No
Radiation Treatment ❒Yes ❒No
Respiratory Disease ❒Yes ❒No
Rheumatic Fever ❒Yes ❒No
Scarlet Fever ❒Yes ❒No
Shortness of Breath ❒Yes ❒No
Sinus Trouble ❒Yes ❒No
Skin Rash ❒Yes ❒No
Special Diet ❒Yes ❒No
Stroke ❒Yes ❒No
Swelling of Feet or Ankles ❒Yes ❒No
Swollen Neck Glands ❒Yes ❒No
Thyroid Problems ❒Yes ❒No
Tonsillitis ❒Yes ❒No
Tuberculosis ❒Yes ❒No
Ulcer ❒Yes ❒No
Tumor/Growth-Head/Neck ❒Yes ❒No
Venereal Disease ❒Yes ❒No
Unexplained Weight Loss ❒Yes ❒No

Are there any other health problems, not listed above, that we should know about? ❒Yes ❒No

Please List: ____

Women:

Are you pregnant? ❒Yes ❒No Due date? ____________ Are you nursing? ❒Yes ❒No

Do you use an Oral Contraceptive or other hormonal therapy? ❒Yes ❒No

DENTAL

Are you unhappy with the appearance of your smile? . . . . ❐Yes ❐No
Have you ever had any unfavorable reaction to local anesthetic? . . . . ❐Yes ❐No
Have you had any serious problems associated with any dental treatment? . . . . ❐Yes ❐No
Do you require antibiotics prior to dental treatment? . . . . ❐Yes ❐No
How long has it been since your last dental visit? . . . .
How long has it been since your last dental X-rays? . . . .

List of Current Medications

____________ ____________ ____________
____________ ____________ ____________

I understand that withholding any information about my health could result in adverse reactions during dental treatment. I have reviewed this medical history and have carefully answered these questions to the best of my knowledge. I also understand it is my responsibility to update this office of any changes in my medical history.

____________ ______ Reviewed by: ____________ ______
Signature Date Doctor Date
Patient, Parent, Guardian

HEALTH HISTORY UPDATE

Date__________ Health Changes and Current Medications________________

Patient Signature________________ Reviewed By Dr. ____________ Date ______

Date__________ Health Changes and Current Medications________________

Patient Signature________________ Reviewed By Dr. ____________ Date______

Date__________ Health Changes and Current Medications________________

Patient Signature________________ Reviewed By Dr. ____________ Date______

Date__________ Health Changes and Current Medications________________

Patient Signature________________ Reviewed By Dr. ____________ Date______