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This information is necessary for our files and will be considered confidential

Patient Name (Last, First & Middle) _____ DOB_____/_____/_____

Medical History

1. Physician's Name: _____
   Address: _____
   Physician's Phone #: (_____) _____
2. Are you under a physician's care? ☐Yes ☐ No
   If yes, since when _____,
   Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication/drug/herbs? ☐Yes ☐ No
   If you need more room please use the Comments section.

Name	Dosage

5. Are you using any cigarette and/or recreational drugs (marijuana, cocaine, etc.)? ☐Yes ☐ No
   If Yes, what: _____
6. Are you taking oral Bisphosphonate? ☐Yes ☐ No
7. Are you allergic to any of these drug or material? ☐Yes ☐ No
   ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa drugs; ☐ Aspirin; ☐ Codeine
   ☐ Latex ☐ Others: _____
8. Have you ever had any serious illness or operation? ☐Yes ☐ No
9. Have you ever been hospitalized? ☐Yes ☐ No
   If so, when _____ why _____
10. Have you had the following conditions: ☐Yes ☐ No
    a. Previous infective endocarditis
    b. Cardiac Transplant
    c. Prosthetic cardiac valve or material used for cardiac valve repair
    d. Congenital Heart Disease
11. Have you ever been pre-medicated with antibiotics for dental treatments? ☐Yes ☐ No
    If yes, when _____ why _____
12. (Women) Are you pregnant or suspect you might be? ☐Yes ☐ No

Do you have or have you had any of the following **(Y for yes, N for no):**

Y	N	AIDS /HIV	Y	N	Avian Flu	Y	N	Excessive Bleeding
Y	N	Anemia	Y	N	Emphysema	Y	N	Cerebral Palsy
Y	N	Asthma	Y	N	Rheumatism	Y	N	Thyroid disease
Y	N	Arthritis	Y	N	Cold Sores	Y	N	Tuberculosis
Y	N	Diabetes	Y	N	Bruise Easily	Y	N	Rheumatic Fever
Y	N	Heart Attack	Y	N	Head injuries	Y	N	Blood Transfusion
Y	N	Herpes	Y	N	Scarlet Fever	Y	N	Joint Replacement
Y	N	Hemophilia	Y	N	Sinus Trouble	Y	N	Artificial Prosthesis
Y	N	Tonsillitis	Y	N	Liver Disease	Y	N	Tumor or Growths
Y	N	Stroke	Y	N	Blood Disease	Y	N	Pain in Jaw Joints
Y	N	Cancer	Y	N	Hepatitis	Y	N	Mental Disorder
Y	N	Ulcers	Y	N	Kidney disease	Y	N	Nervous Disorder
Y	N	Fen-Phen				Y	N	Heart Disease
Y	N	Redux	Y	N	Pace Maker	Y	N	Heart Murmur
Y	N	Anthrax	Y	N	Rubella	Y	N	Heart Valve Implant
Y	N	SARS	Y	N	Pneumonia	Y	N	Malaria
Y	N	Chicken Pox	Y	N	Diphtheria	Y	N	Mumps
Y	N	Smallpox	Y	N	High Blood Pressure	Y	N	High Cholesterol
Y	N	Measles	Y	N	Pharyngitis	Y	N	Seasonal Flu
Y	N	Shingles	Y	N	Angina Pectoris	Y	N	Pertussis or Whooping Cough

Dental History

1. Purpose of this visit? _____
2. Previous Dentist's Name: _____
3. Previous Dentist's Address & Phone: _____
4. When was your last dental visit? (MM/YY) _____ Do you visit your dentist regularly? ☐Yes ☐ No
5. What was done at that visit? _____
6. Have any of your teeth been removed? ☐Yes ☐ No If yes, Why? _____
7. Do you clench/grind/have pain or soreness in the muscles of your face? ☐Yes ☐ No
8. Are you experiencing any sensitivity? ☐Yes ☐ No
9. How often do you brush your teeth? _____/day
10. Do you floss? ☐Yes ☐ No If yes, how often? _____/day
11. Have you had any orthodontic work? ☐Yes ☐ No
12. Do you snore or have trouble sleeping? ☐Yes ☐ No
13. Have you had any complications with previous dental treatments? ☐Yes ☐ No
    If yes, please explain: _____
14. Have you had any unpleasant dental experiences? _____
15. Do you have any questions or concerns? _____

Comments:

_____
_____
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_____
_____

Consent for treatment:

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as many be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedure, anesthetics and/or drugs. I certify that the above information is complete and accurate.

Authorization must be signed by the patient, or by the nearest relative or guardians in the case of a minor or when the patient is physically or mentally incompetent.

Signature X_____ **Date** _____/_____/_____ **Relationship to patient** _____

Dentist Reviewed By:_____