HEALTH HISTORY

Patient Name: ______________________ Date: ______________________

Weight: __________ Height: __________ Date of Last Dental Visit: ______________

Name of Physician: ______________________ Phone: ______________________

Emergency Contact: ______________________ Phone: ______________________

Please list your chief dental complaint: ______________________________

Do you have or have you ever had any of the following? Please check all that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints/Implants
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding/Bruising
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mononucleosis
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Snoring/Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery
- ☐ Jaw & Joint Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: ______________

Are you using any of the following? Please check all that apply and list the name of each medication:

- ☐ Allergy Medications ______________
- ☐ Antibiotics ______________
- ☐ Anti-Depressants ______________
- ☐ Aspirin or other Pain Relievers (Motrin, Aleve, Ibuprofen) ______________
- ☐ Asthma Medications ______________
- ☐ Bisphosphonates (Boniva, Fosamax, Reclast, Zometa, etc.) ______________
- ☐ Blood Thinners (Coumadin, Fish Oil, Ginko Biloba, Plavix, etc.) ______________
- ☐ Diet Pills ______________
- ☐ High Blood Pressure Medications ______________
- ☐ Insulin or other Diabetic Medications ______________
- ☐ Nitroglycerin ______________
- ☐ Steroids (Cortisone, Prednisone, etc.) ______________
- ☐ Tranquilizers or Sleeping Pills ______________
- ☐ Vitamins or Minerals ______________
- ☐ Other Medications ______________

Are you allergic to any of the following? Please check all that apply:

- ☐ Aspirin or Ibuprofen
- ☐ Codeine or other Pain Killers
- ☐ Food Products
- ☐ Jewelry
- ☐ Latex or Rubber Products
- ☐ Local Anesthesia
- ☐ Metal of any kind
- ☐ Penicillin or other Antibiotics
- ☐ Sedatives, Tranquilizers, Sleeping Pills
- ☐ Sulfa Drugs
- ☐ Other: ______________

Please circle Yes or No for the following:

Yes / No Do you smoke or chew tobacco?
Yes / No Do you have any history with alcohol or substance abuse?
Yes / No Have you had any serious problems associated with dental treatment?
Yes / No Have you or any family member had any problems associated with anesthesia?
Yes / No Has a doctor ever recommended taking antibiotics prior to dental treatment?
Yes / No Do you have any disease, condition, or problem not listed above that you think the doctor should know?
Yes / No Do you wish to talk to the doctor privately about anything?
Yes / No Are you currently under a doctor's care for anything?

WOMEN ONLY, Please circle Yes or No:

Yes / No Is there a possibility you're pregnant? If so, expected due date? ______________
Yes / No Are you currently nursing?
Yes / No Are you taking birth control pills?

I understand the importance of a truthful and complete health history to assist my dentist in providing the best care possible. I have read and understand the above. I understand it is my responsibility to fill out this form correctly and completely. If I have any changes in my medical information, I understand it is my responsibility to inform the doctor at my next appointment.

Patient or Parent/Guardian's Signature: ______________________________