HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for? _____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason: _____

Are you currently receiving care or have had a physical within the past 2 years? No Yes

If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

	No	Yes		No	Yes
Acid Reflux			Heart Stent When placed?		
Angranulocyctosis			Hepatitis, Any Form		
Anemia or Blood Disorder			H.I.V. Infection/AIDS or ARC		
Arthritis, Rheumatism or other inflammatory disease			Joint Replacement When placed?		
Asthma			Kidney Disease		
Abnormal Bleeding from a cut			Liver Disease (including Jaundice)		
Blood Disorder			Sore/Enlarged Lymph Nodes		
Cancer or Tumor			Osteoporosis		
Diabetes I or II			Pace Maker		
Emphysema or other Respiratory/Lung Illnesses			Previous Biopsies		
Epilepsy/Seizures			Psychosis		
Fainting or Dizzy Spells			Radiation or Chemo Treatment		
Glaucoma			Recurrent Illnesses		
Head Injury			Sinus Problems		
High Blood Pressure, Hypertension			Slow-Healing Mouth Sores		
Abnormal Heart or Previous Bacterial Endocarditis			Stomach Problems		
Congenital Heart Disease			Stroke		
Heart Valve (artificial) or Heart Transplant			Tuberculosis		
Heart Valve Dysfunction			Ulcers		
Heart Disease, Heart Attack, Heart Surgery			Unintentional Weight Loss/Gain		

Other conditions or surgeries not listed above?

Please explain:_____

Do you need to take an antibiotic before dental care? No Yes Reason: _____

Please list any medications you are currently taking and dosages:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Women:	Are you pregnant?	No	Yes
	If no, are you planning a pregnancy in the near future?	No	Yes
	Are you a nursing mother?	No	Yes
	Are you taking birth control pills?	No	Yes

Are you allergic or have you had a reaction to the following?

a.	Local anesthetics ……..	No	Yes
b.	Penicillin or other antibiotics ……..	No	Yes
c.	Aspirin, Ibuprofen or Tylenol …….	No	Yes
d.	Codeine, Valium® or other sedatives……	No	Yes
e.	Latex …….	No	Yes
f.	Metals ……...	No	Yes
g.	Food Substances or Dyes	No	Yes
h.	Other (please specify) _____		

Do you use tobacco? If yes, smoke or chew How much per day? For how long?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of changes in my health and medication.

_____ _____ _____

Patient / Legal Guardian (Print Name) Patient / Legal Guardian Signature Date