Health History

PATIENT'S FULL NAME _____
BIRTH DATE _____ SEX _____ AGE _____
NAME OF PHYSICIAN _____ PHONE# _____ DATE OF LAST EXAM _____

Are you having pain or discomfort at this time?	☐ YES	☐ NO
Do you feel very nervous about having dental treatment?	☐ YES	☐ NO
Have you been under the care of a medical doctor during the past two years?	☐ YES	☐ NO
Are you taking Coumadin or any other blood thinner?	☐ YES	☐ NO
Are you taking any medication, drugs or pills?	☐ YES	☐ NO

If yes, please explain: _____

_____

ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO ANY OF THE FOLLOWING: (Please Circle)

Amoxicillin	Latex	Valium	Local anesthetic
Aspirin	Nitrous Oxide	Scopolamine	(Novocain or Xylocaine)
Darvon	Erythromycin	Penicillin	Sleeping Pills
Codeine	Tetracycline	Other antibiotics	(Nembutal/Seconal)
Demerol	Percodan		

Have you ever been told by a physician that you need to be premedicated before dental work? ☐ YES ☐ NO
Are you currently using tobacco products or have you used tobacco products in the past? ☐ YES ☐ NO
If YES, what? _____ How long? _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT:

A.I.D.S	Drug Addiction	Liver Disease
Anemia	Emphysema	Mitral Valve Prolapse
Angina Pectoris	Epilepsy or Seizures	Orthodontics
Arthritis	Fainting or Dizzy Spells	Pain in Jaw Joints
Artificial Heart Valve	Fever Blisters	Periodontal Treatment
Artificial Joints (hips, knees)	Glaucoma	Psychiatric Treatment or Mental Disorder
Asthma	Heart Disease or Attack	Radiation Treatment
Blood Transfusion	Heart Murmur	Rheumatic Fever
Cancer	Heart Pacemaker	Scarlet Fever
Canker Sores	Hemophilia	Sickle Cell Disease
Congenital Heart Lesions	Hepatitis A (infectious)	Sinus Trouble
Contact Lenses	Hepatitis B (serum)	Stents _____ Date
Cortisone Medicine	Hepatitis C	Stroke
Dental Implants	High Blood Pressure	Thyroid Disease
Diabetes	Kidney Trouble	Tuberculosis

FOR WOMEN ONLY:

Are you pregnant?	☐ YES	☐ NO	If yes, what month? _____
Are you taking birth control pills?	☐ YES	☐ NO	(*Antibiotics may reduce the effectiveness of birth control pills.*)
Are you nursing?	☐ YES	☐ NO	

Reason for today's visit _____
Former Dentist _____ City/State _____
Date of last dental visit _____ Date of last dental x-rays _____
How often do you brush? _____ How often do you floss? _____

I understand that the above information is confidential and certify that it is correct to the best of my knowledge.

DATE _____ PATIENT/PARENT OR GUARDIAN SIGNIATURE_____