HEALTH HISTORY

Physician's Name(s)______________________________

Date of last visit(s)____________________ Are you undergoing any treatments or therapies?____________________

Have you ever been hospitalized or had a major operation? Yes / No If yes, please name: ____________________

Do you use tobacco? Yes / No If yes, what type and how often: ____________________

Circle "yes" to indicate if you have or have ever had the following:

AIDS/HIV	Yes / No		Excessive Bleeding	Yes / No		Psychiatric Care	Yes / No
Alzheimer's Disease	Yes / No		Fainting or Dizzy Spells	Yes / No		Radiation Treatment	Yes / No
Anemia	Yes / No		Glaucoma	Yes / No		Respiratory Disease	Yes / No
Arthritis, Rheumatism	Yes / No		Headaches	Yes / No		Rheumatic Fever	Yes / No
Artificial Heart Valves	Yes / No		Heart Attack/Failure	Yes / No		Scarlet Fever	Yes / No
Artificial Joints	Yes / No		Heart Murmur	Yes / No		Sexually Transmitted Disease	Yes / No
Asthma	Yes / No		Heart Problems	Yes / No		Sickle Cell Disease	Yes / No
Back Problems	Yes / No		Hepatitis Type__________	Yes / No		Shortness of Breath	Yes / No
Blood Disease	Yes / No		Herpes	Yes / No		Sinus Trouble	Yes / No
Cancer	Yes / No		High Blood Pressure	Yes / No		Skin Rash	Yes / No
Chemical Dependency	Yes / No		High Cholesterol	Yes / No		Special Diet	Yes / No
Chemotherapy	Yes / No		Jaundice	Yes / No		Stroke	Yes / No
Circulatory Problems	Yes / No		Kidney Disease	Yes / No		Swollen Feet or Ankles	Yes / No
Congenital Heart Defect	Yes / No		Liver Disease	Yes / No		Thyroid Problems	Yes / No
Cortisone Treatments	Yes / No		Low Blood Pressure	Yes / No		Tonsillitis	Yes / No
Cough, persistent or bloody	Yes / No		Low Blood Sugar	Yes / No		Tuberculosis	Yes / No
Diabetes	Yes / No		Mitral Valve Prolapse	Yes / No		Tumor or growth on head or neck	Yes / No
Emphysema	Yes / No		Nervous Problems	Yes / No		Ulcer	Yes / No
Epilepsy (seizures)	Yes / No		Pacemaker	Yes / No		Unexplained Weight Loss	Yes / No

Any other illness or condition not listed above? ____________________

Women: Are you pregnant? Yes / No Nursing? Yes / No Trying to get pregnant? Yes / No Taking Oral Contraceptives? Yes / No

MEDICATIONS

Please list all medications you are currently taking:

____

____

____

____

____

____

Pharmacy name and number______________________________

ALLERGIES

Please circle any of the following that you have an allergy to and list the type of reaction it causes.

Aspirin ______________

Codeine ______________

Iodine ______________

Latex ______________

Local Anesthetic ______________

Penicillin ______________

Sulfa ______________

Other ______________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status or medications.

Signature of Patient, Parent, or Guardian ______________________________ Date ______________