HEALTH HISTORY

PATIENT NAME_____ **DATE OF BIRTH**_____

1. Are you now under the care of a physician? _____
   If so, what is the condition being treated? _____
2. Have you ever had excessive bleeding after an extraction, or do cuts take longer to heal than previously?_____ Yes No
3. (Women) Are you pregnant? If so, give due date_____ Yes No
4. Do you use tobacco in any form? If yes, how much?_____ Yes No
5. Have you been told you need to premedicate for dental work?_____ Yes No
6. Do you have, or have you ever had, any of the following? Please circle Yes or No.

GENERAL HEALTH
Tire easily/ weakness_____ Yes No
Persistent fever_____ Yes No

SKIN
Eruptions (rash), hives_____ Yes No

EYES
Glaucoma_____ Yes No

EARS/NOSE/THROAT
Loss of hearing_____ Yes No
Ringing in ears_____ Yes No
Frequent nose bleeds_____ Yes No
Sinus problems_____ Yes No
Soreness/hoarseness_____ Yes No

ENDOCRINE
Diabetes_____ Yes No
Family history of diabetes_____ Yes No
Thyroid condition/goiter_____ Yes No
Other_____ Yes No

NERVOUS SYSTEM
Stroke_____ Yes No
Headaches_____ Yes No
Convulsions/epilepsy_____ Yes No
Numbness/tingling_____ Yes No
Psychiatric treatment_____ Yes No
Dizziness/fainting_____ Yes No

RESPIRATORY
Tuberculosis_____ Yes No
Emphysema_____ Yes No
Asthma/hay fever_____ Yes No
Persistent cough_____ Yes No
Sputum production (phlegm)_____ Yes No
Difficulty breathing while lying down_ Yes No

OTHER
Radiation/Chemotherapy_____ Yes No
Artificial Joints_____ Yes No
Tumors/growths_____ Yes No

HEART/BLOOD VESSELS
Rheumatic fever_____ Yes No
Heart murmur_____ Yes No
Chest pain/discomfort_____ Yes No
Heart attack/heart trouble_____ Yes No
Shortness of breath_____ Yes No
Swelling of ankles_____ Yes No
High blood pressure_____ Yes No
Congenital heart disease_____ Yes No
Mitral valve prolapse_____ Yes No
Artificial heart valve_____ Yes No
Pacemaker_____ Yes No
Heart surgery_____ Yes No
Other_____ Yes No

OTHER
Cancer_____ Yes No
HIV+/AIDS_____ Yes No
Hepatitis_____ Yes No

7. Please list any **ALLERGIES** to medications:_____
8. Are you taking any of the following?

Antibiotics/sulfa drugs_____ Yes No
Blood thinners_____ Yes No
Blood pressure medication_____ Yes No
Thyroid medication_____ Yes No
Aspirin_____ Yes No
Insulin/other diabetes drugs_____ Yes No
Digitalis/other heart medications____ Yes No
Nitroglycerin_____ Yes No

9. Please list all medications that you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

10. If you are an existing patient, please list any surgeries and/or hospitalizations since your last dental appointment:_____

_____

_____

PLEASE CONTINUE TO OTHER SIDE

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? _____

_____

12. Physician's name_____ Phone_____

NEW PATIENTS ONLY:

13. Have you ever had any serious trouble associated with previous dental treatment?_____

_____

14. Does dental treatment make you nervous? No_____Slightly_____Moderately_____Extremely_____

15. Date of last dental visit_____ Name of dentist_____

16. Have you ever been treated for periodontal disease (gum disease)?_____

If so, when?_____

17. Is there anything you don't like about your smile?_____

_____

18. Do you have any dental concerns?_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or change in my medication, I will inform the dentist at my next appointment.

Signature of Patient, Parent or Guardian_____ Date_____
(required)

Print Name_____

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM ACCURATELY!

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