PATIENT'S NAME_____ DATE OF BIRTH_____

HEALTH HISTORY FORM

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health issues that you have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving.

Please CIRCLE "YES" or "NO" and answer the following questions :

1. Are you in good general health……YES/NO
2. Have there been any changes in your general health in the last year?.....YES/NO
3. Are you under the care of a physician……..YES/NO
4. Date of your last physical exam_____
5. Physician's name_____
6. Physician's phone number_____
7. Have you ever been hospitalized for any serious illness or surgical procedure…….YES/NO
8. Do you bruise easily……..YES/NO
9. Have you had any abnormal bleeding……..YES/NO
10. Are you taking **any medicine(s)**, prescription OR over-the-counter/non-prescription….YES/NO
    IF YES, PLEASE LIST ANY MEDICATIONS, HERBAL SUPPLEMENTS, AND VITAMINS TAKEN:
    _____
    _____
11. Have you ever required a blood transfusion……YES/NO
12. Have you had recent weight loss……..YES/NO
13. Do you use tobacco……YES/NO
14. Do you or have you used controlled substances or recreational/street drugs……..YES/NO
15. Are you wearing contact lenses……YES/NO
16. Do you have any disease, condition, or medical issue not listed above that you think the dentist should be informed about…….YES/NO
    If yes, please explain:_____
17. WOMEN ONLY:
    Are you pregnant or think you may be pregnant……YES/NO
    Are you nursing……YES/NO
    Are you taking birth control……YES/NO

Do you currently have or have you ever had the following medical conditions:

Heart disease	YES/NO	Cancer (Chemotherapy/radiation)	YES/NO
Heart trouble	YES/NO	Glaucoma	YES/NO
Heart attack	YES/NO	Tuberculosis	YES/NO
Angina/ Chest Pain	YES/NO	Blood Thinners (Coumadin, Warfarin, Plavix, Aspirin, etc)	YES/NO
Artificial heart valve	YES/NO	Sexually Transmitted Disease	YES/NO
Heart surgery	YES/NO	Cold Sores/Fever Blisters	YES/NO
Congenital heart defect	YES/NO	Rheumatic Fever	YES/NO
Stents	YES/NO	Scarlet Fever	YES/NO
Mitral Valve Prolapse	YES/NO	Asthma	YES/NO
Heart Murmur	YES/NO	Shortness of Breath	YES/NO
Rheumatic Heart Disease	YES/NO	Lung or Breathing Problems	YES/NO
High Blood Pressure	YES/NO	COPD/Emphysema	YES/NO
Low Blood Pressure	YES/NO	Sinus Trouble	YES/NO
Swelling of feet, ankles, hands	YES/NO	Persistent Cough	YES/NO
Pacemaker	YES/NO	Cough that produces blood	YES/NO
Stroke	YES/NO	Epilepsy or Seizures	YES/NO
AIDS/HIV	YES/NO	Parkinson's Disease	YES/NO
Hepatitis A	YES/NO	Anemia	YES/NO
Hepatitis B	YES/NO	Diabetes (Type I or Type II)	YES/NO
Hepatitis C	YES/NO	Hypoglycemia	YES/NO
Liver Disease	YES/NO	Eating Disorder	YES/NO
Artificial Joints (knee, hip, etc)	YES/NO		

PATIENT'S NAME_____ DATE OF BIRTH_____

HEALTH HISTORY FORM con't

Thyroid Problems	YES/NO	Fainting or Dizziness	YES/NO
Stomach Ulcer	YES/NO	Chemical Dependency (drugs and/or alcohol)	YES/NO
Kidney Problems	YES/NO	Other medical condition not listed:	
Mental Health Care	YES/NO	_____	
Back Problems	YES/NO		
Hives or Skin Rash	YES/NO		

Are you allergic to or have had an allergic reaction :

Latex or rubber YES/NO

Antibiotics YES/NO If yes, please list which one(s)_____

Local anesthetics like novocaine YES/NO

PLEASE LIST ANY OTHER ALLERGIES:

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____

Date:_____