Health History

Name: _____ Date of Birth: _____ Date: _____

Preferred Contact Phone #: _____ Email Address: _____

Your medical history is an integral part of how we treat you. Your mouth and your body act and react together. Diseases and medications you may think are not important to us, can affect the course of treatment. Please answer all questions accurately so we can provide the best care possible. Thank You.

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery, etc.) **No Yes,** Explain _____

Any form of cancer? **No Yes**, Type or name. When diagnosed? _____

Date of last physical _____ Physician _____

Are you under the care of a physician? **No Yes**, For what condition _____

Please list any medications or supplements you take: _____

_____

Does your physician require you take any medication prior to having dental work done?

No Yes, Explain _____

Physician's Name: _____ Address: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

YES NO	Allergies	YES NO	Hypoglycemia
YES NO	Anorexia	YES NO	Hypothyroid
YES NO	Are you an alcoholic	YES NO	Kidney disease
YES NO	Arthritis: Rheumatoid Osteoarthritis	YES NO	Liver disease, jaundice
YES NO	Artificial Joints, Date Placed: _____	YES NO	Low blood pressure
YES NO	Asthma	YES NO	Mental disorder
YES NO	Back pain, surgery	YES NO	Migraine headaches
YES NO	Bleeding problems	YES NO	Organ transplant
YES NO	Blood disorder, anemia	YES NO	Pain in chest, shortness of breath
YES NO	Bulimia	YES NO	Pacemaker
YES NO	Cold sores	YES NO	Persistent cough
YES NO	Chemo Treatment	YES NO	Radiation treatment
YES NO	Circulation problems (swollen ankles, etc.)	YES NO	Respiratory problems
YES NO	Diabetes	YES NO	Rheumatic fever
YES NO	Dizziness, fainting spells	YES NO	Sinus problems
YES NO	Epilepsy	YES NO	Stroke
YES NO	Glaucoma	YES NO	Tobacco use
YES NO	Head or neck injury	YES NO	Tuberculosis
YES NO	Heart attack	YES NO	Ulcers
YES NO	Heart Disease	YES NO	Use controlled substance
YES NO	Heart Murmur	YES NO	Venereal disease
YES NO	Hepatitis A, B, C	YES NO	Whiplash injury
YES NO	High Blood Pressure	YES NO	Women, are you pregnant
YES NO	HIV/AIDS	YES NO	Women, are you taking birth control

Do you have any disease, condition or problem not listed above we should know about?

_____

Are you sensitive or allergic to any of the following:

YES NO	Acrylic	YES NO	Ibuprofen	YES NO	Sulfa
YES NO	Aspirin	YES NO	Iodine		
YES NO	Codeine/pain pills	YES NO	Mercury	Other: _____	
YES NO	Latex/Rubber	YES NO	Nickel		
YES NO	Lidocaine/Novocain	YES NO	Penicillin		

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Hygienist Signature: _____ Date: _____