Health History

Patient Name:_____ Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or redux? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other other medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant/trying to get pregnant? ☐ Yes ☐ No Due Date:_____

Taking oral contraceptives? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following?:

Aspirin___ Barbiturates___ Codeine___ Iodine___ Latex___ Local Anesthetic___ Penicillin___ Sulfa___

Other_____

Do you have, or have you had any of the following?

AIDS/HIV	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Back/Neck/Head Problems or Injury	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Bleeding abnoramally with extractions or surgery	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Congentital Heart Lesions	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Swollen Neck glands	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Tumor/growth on head/neck	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Hepatitis Type___	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

Herpes ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No

Weight Loss, unexplained ☐ Yes ☐ No

Patient Signature:_____