HEALTH HISTORY

Mr. Mrs. Ms. Dr. Home Phone# Cell Phone#
ADDRESS Date of Birth
City State Zip Height Weight
Occupation E-mail SSN
Business Name and Address Work Phone #
Emergency Contact Name Phone #
Pharmacy Name and Location
Who referred you to our office/who is your general dentist?

DENTAL INFORMATION (Please place an 'X' where it applies.)

YES	NO	UNKNOWN	
○	○	○	Do you currently have any pain or sensitivity?
			If yes, explain:
○	○	○	Has a physician ever recommended antibiotics prior to dental treatment (pre-med)?
○	○	○	Do you currently take antibiotics (pre-med) prior to dental treatment?
			If yes, what antibiotic do you take?
○	○	○	Have you had a serious/difficult problem with dental treatment?
			If yes, explain:

MEDICAL INFORMATION

Primary Physician: Phone #
Please list any specialists:

YES	NO	UNKNOWN	
○	○	○	Do you feel healthy today?
○	○	○	Are you in good health?
○	○	○	Has there been any change in your general health within the past year?
○	○	○	Do you smoke? If yes, how many years have you smoked?

How much do you smoke daily?

Do you have any of the following diseases or problems?

○	○	○	Active Tuberculosis
○	○	○	Persistent cough
○	○	○	Fever, malaise, or weight change within the last 2 weeks?
○	○	○	Serious illness, operation/surgery, or hospitalization within the last 5 years?
			If yes, explain:
○	○	○	Artificial joint replacement
○	○	○	History of heart surgery
○	○	○	Autoimmune Disorders
○	○	○	Osteoporosis and/or Bisphosphonate use
○	○	○	Diabetes: ☐ Type 1 ☐ Type 2 If yes, most recent A1C and date of test?
○	○	○	Are you alcohol and/or drug dependent?
○	○	○	Do you use drugs or other substances for recreational purposes?

Please list any medications (and dosages) you are taking, including any herbal remedies, vitamins, and supplements:

Allergies: Are you allergic to, or have you had a reaction to:

YES	NO		YES	NO	
○	○	Local Anesthetics	○	○	Latex, Band-aids, Rubber
○	○	Aspirin	○	○	Barbiturates, Sedatives
○	○	Penicillin	○	○	Sulfa Drugs
○	○	Codeine or narcotics	○	○	Food

Other (please specify)

If yes to any allergy, please specify type of reaction:

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MEDICAL INFORMATION CONTINUED
(Please place an 'X' where it applies, even if condition is controlled with medication.)

YES	NO	UNKNOWN		YES	NO	UNKNOWN	
○	○	○	Abnormal Bleeding	○	○	○	Heart Attack
○	○	○	AIDS or HIV Infection	○	○	○	Heart Murmur
○	○	○	Anemia	○	○	○	High Blood Pressure
○	○	○	Angina	○	○	○	High Cholesterol
○	○	○	Arthritis	○	○	○	Hip Replacement
○	○	○	Artificial Heart Valves	○	○	○	Kidney Problems
○	○	○	Asthma	○	○	○	Knee Replacement
○	○	○	Cancer/Chemotherapy/Radiation	○	○	○	Mental Health Disorders
○	○	○	Chest pains upon exertion	○	○	○	Mitral Valve Prolapse
○	○	○	Chronic Pain	○	○	○	Pacemaker
○	○	○	Claustrophobic	○	○	○	Persistent Diarrhea
○	○	○	Diabetes ☐ Type 1 ☐ Type 2	○	○	○	Recurrent Infections
○	○	○	Immunosuppression (Drug, disease, or radio induced)	○	○	○	Respiratory Problems
				○	○	○	Rheumatic Heart Disease
○	○	○	Epilepsy	○	○	○	Sinus Trouble
○	○	○	Esophageal Reflux	○	○	○	Stroke
○	○	○	Excessive urination	○	○	○	Thyroid Problems
○	○	○	Fainting Spells/Seizures	○	○	○	Ulcers/Heartburn
○	○	○	Glaucoma				

Do you have any disease, condition, or problem not listed above? If so, please explain:

(Women Only)

YES	NO	UNKNOWN	
○	○	○	Are you pregnant?
○	○	○	Taking birth control pills? (Antibiotics may inactivate birth control pills.)
○	○	○	Are you nursing?

Both the doctor and patient are encouraged to discuss any other relevant patient issues prior to treatment. I consent to have necessary examination and x-rays completed. I acknowledge that I am responsible for fees for services rendered. I understand that it is my obligation to return for advised follow up appointments. I understand that if there are any post-operative problems or misunderstandings, it is my obligation to return.

I certify that I have read and understand the above. I certify that I have answered all questions truthfully to the best of my knowledge. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Signature of Dentist Date

Health History Update: The patient should review this document to update any changes yearly. A new form should be completed every two years.

_____ _____ _____
Date of Update Signature of Patient Signature of Dentist