



HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

- Are you in good health? Yes No
- Date of last physical examination: _____
- Are you now under the care of a physician? Yes No
If yes, what is the condition being treated? _____
Doctor's name: _____ Telephone #: _____
- Have you ever had any serious illness or operation or been hospitalized? Yes No
Please explain: _____
- Are you taking any medication? Yes No
If yes, what? _____ What dosage? _____
- Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? Yes No
If yes, what? _____
- Have you ever been premedicated with antibiotics for your dental treatment? Yes No
- Are you sensitive or allergic to any drugs or materials? Penicillin Tetracycline Erythromycin
 Aspirin Codeine Latex Other If Other, please list: _____ Yes No
- Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies or Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis or Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty in Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Angina Pectoris	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N TMJ
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Ailments or Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors or Growths
<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	
- Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
- Do you smoke, chew, use snuff or any other forms of tobacco? Cigarettes Cigars Chew Snuff Other Yes No
If yes, how much? _____
- Do you consume alcoholic beverages? If yes, how much? _____ Yes No
- Have you ever taken the drug "Fen-Phen" or "Redux"? Yes No
- Are you pregnant? If yes, how many months? N/A Yes No
- Do you have any problems associated with your menstrual period? N/A Yes No
- Do you take birth control pills? N/A Yes No
- Is there anything we should know about your health that is not mentioned above? Yes No
Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd UPDATE — Since your last visit:
1. Have you seen a medical doctor? Yes No
2. Have you had a change in any medication? Yes No
3. Have you had a change in any medical condition or had surgery? Yes No
If yes, please explain: _____
Date: _____ Signature: _____

3rd UPDATE — Since your last visit:
1. Have you seen a medical doctor? Yes No
2. Have you had a change in any medication? Yes No
3. Have you had a change in any medical condition or had surgery? Yes No
If yes, please explain: _____
Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE					
	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1st	_____	____/____	_____	_____	_____
2nd	_____	____/____	_____	_____	_____
3rd	_____	____/____	_____	_____	_____