HEALTH HISTORY

Today's Date:_____

Name: _____Phone # _____DOB: _____ Referring Dentist: _____

Emergency Contact Name_____Relationship _____ Phone:_____ Alt. Phone _____

Are you under the care of a physician for any illness or health problem (for the last two years)? **YES NO**

Date of last exam _____Medical record # _____

Physicians: 1. _____ Phone _____Specialty _____

2._____ Phone _____Specialty _____

Do you have or have you had any of the following health conditions?	**PLEASE provide information for all YES answers**
Are you required to take any antibiotics prior to dental treatment?	YES NO
Rheumatic Fever/Scarlet Fever/Rheumatic or Congenital Heart Disease/Heart Murmur/Mitral Valve Prolapse	YES NO
Heart Trouble/Heart Attack/Angina/Heart Pacemaker	YES NO
Artificial Limb, Joint or Heart Valve	YES NO
Stroke	YES NO
High/Low Blood Pressure	YES NO
Fainting Spells, Seizures/Epilepsy	YES NO
Diabetes	YES NO
Do you have a family history of Diabetes?	YES NO
Restricted Diet of Any Kind	YES NO
Cancer/Tumors	YES NO
Kidney Trouble	YES NO
Respiratory Lung Disorders/Tuberculosis/Asthma/Emphysema/Etc.	YES NO
Stomach or Intestinal Problems	YES NO
Excessive Bleeding, Bruising or Anemia	YES NO
Hepatitis, Jaundice, Liver Disease	YES NO
Cold Sores/Herpes	YES NO
HIV, ARC, AIDS, Syphilis/Gonorrhea	YES NO
Do you now take or have you ever taken Medication for Osteoporosis/Cancer (bone altering medication) such as Fosomax, Boniva or Denosumab?	YES NO
Arthritis	YES NO
Glaucoma	YES NO
Psychiatric Care	YES NO
Do you have a history of drug or alcohol abuse?	YES NO
Do you smoke?	YES NO If Yes, how many per day? _____
If you are a woman, are you pregnant or planning pregnancy?	YES NO
Does your health restrict your physical activity in any way?	YES NO
Are you taking **ANY** prescriptions and/or over-the-counter medications?	YES NO
Please list: _____	
Do you have any allergies or adverse side effects to any drugs or medications?	YES NO
Any allergies such as Novocaine, Xylocaine, Aspirin, Penicillin, Codeine, Fluoride, Mouthwash, or Latex?	
Please list: _____	
Do you have any disease, condition or handicap not listed above? (please list)	YES NO
List Major Surgeries/Hospitalizations:	

I CERTIFY THAT THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.

Patient/Guardian's Signature_____ Reviewed by Dr. _____ Date _____

HEALTH UPDATE -- DOCTOR USE ONLY

Date Reviewed_____ By Hyg. _____ By Pt. _____ Changes _____

Date Reviewed_____ By Hyg. _____ By Pt. _____ Changes _____

Date Reviewed_____ By Hyg. _____ By Pt. _____ Changes _____