Health History Form

Patient Information:

Patient Name______________________________________ Date of Birth________________________________

Name of **Spouse** or **Parent**____

Address ____

City_______________________ State_____________________ Zip ___________________________________

Home Phone _____________ Cell Phone _______________ Email_____________________________________

Occupation________________________ Work Phone ____

Who may we thank for referring you? ____

Emergency Contact______________________________ Phone ____

Medical History:

Please List ALL Surgery History ____

****Have you ever taken *pre-medication* before dental visits? __Y__N Why?** _________________________

Any heart conditions? Please list ____

***Women:** Are you pregnant? __Yes ___No / Nursing? __Yes __No / Birth Control? __Yes__No

History of taking the following medications? Fosamax, Actonel, Atelvia, Dodronel, Boniva? __Yes__No

List all drug allergies: ____

Food Allergies:____

__**Y**__**N** AIDS/HIV positive
__**Y**__**N** Arthritis, Rheumatism
__**Y**__**N** Artificial Heart Valve
__**Y**__**N** Artificial Joint(s)? ______________
__**Y**__**N** Anemia
__**Y**__**N** Asthma
__**Y**__**N** Back Problems
__**Y**__**N** Cancer
__**Y**__**N** Chemotherapy
__**Y**__**N** Circulatory Problems
__**Y**__**N** Cortisone Treatments
__**Y**__**N** Diabetes. *Type I_____ or Type II_______*
__**Y**__**N** Rheumatic/Scarlet Fever
__**Y**__**N** Stroke
__**Y**__**N** Thyroid Disease
__**Y**__**N** Tobacco Habit
__**Y**__**N** Tonsilitis
__**Y**__**N** Tuberculosis
__**Y**__**N** Hepatitis
__**Y**__**N** Epilepsy
__**Y**__**N** Fainting
__**Y**__**N** Glaucoma
__**Y**__**N** Headaches
__**Y**__**N** Heart Murmur
__**Y**__**N** Heart Surgeries___________________
__**Y**__**N** Herpes
__**Y**__**N** Kidney Disease
__**Y**__**N** Liver Disease
__**Y**__**N** Latex/material allergy
__**Y**__**N** Mitral Valve Prolapse (MVP)
__**Y**__**N** Pacemaker
__**Y**__**N** Psychiatric Care
__**Y**__**N** Rapid weight gain/loss
__**Y**__**N** Radiation Treatment
__**Y**__**N** Respiratory Disease
__**Y**__**N** Hepatitis
__**Y**__**N** High Blood Pressure
__**Y**__**N** High Cholesterol

List all Current Medications:

1.__________________ 2. _________________ 3. ___________________ 4. ____________________

5.__________________ 6._________________ 7._____________________ 8.____________________

Please turn page to complete backside portion

Date of last cleaning____________________________ Date of last X-rays__________________________

__**Y**__**N** Bleeding Gums

__**Y**__**N** Periodontal Treatment

__**Y**__**N** Clicking/Popping in Jaw

__**Y**__**N** Hot and cold sensitivity?

__**Y**__**N** Grinding/Clenching Teeth

__**Y**__**N** Bite Sensitivity

__**Y**__**N** Loose or Broken Teeth

Patient Signature: ____

Date:__________________________