_Health History

Patient Name____

Please check and circle all that apply:

☐ Heart Disease
☐ Heart Attack/Heart Defects
☐ Pacemaker/Artificial Valve
☐ Heart Murmur
☐ High/Low Blood Pressure (Please circle High or Low)
☐ Bleeding/Blood Thinners/Hemophilia
☐ Anemia
☐ Stroke
☐ High Cholesterol
☐ Artificial Joint (Location and year) __________
☐ Diabetes/Last A1C _______________
☐ Epilepsy/Seizures
☐ Severe/Frequent Headaches
☐ Sleep Apnea/CPAP
☐ TMJ
☐ Asthma/Emphysema/Difficulty Breathing
☐ Sinus Trouble/Seasonal Allergies
☐ Cancer/Chemotherapy/Radiation Treatment
☐ Osteoporosis
☐ Hepatitis/Other Liver Diseases
☐ Kidney Disease
☐ Thyroid Disease
☐ Stomach Problems/Ulcers/GERD/Colitis
☐ Shingles
☐ HIV/AIDS
☐ Tuberculosis
☐ Drug/Alcohol Dependence
☐ Mental Health Condition
☐ Other: Explain: ____

Are you allergic to or have you had a reaction to?

☐ Local Anesthetics
☐ Aspirin
☐ Penicillin or Antibiotics
☐ Sulfa Drugs
☐ Latex
☐ Codeine or Other Narcotics
Other: ____

For women only:

☐ Are you taking birth control pills?
☐ Are you pregnant?
☐ Are you nursing?

Medications:

List all medications you take (both prescription and over the counter) We can photocopy your prepared list.

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• Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:
____

• Have you been admitted to a hospital or needed emergency care recently? ☐ Yes ☐ No
If yes, please explain: ____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____________________ Patient's Signature (or Parent if minor) ________________________________