HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____
Height_____ Weight_____
Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.	YES	NO
1. Are you in good health now? ----------	___	___
2. Are you now under the care of a physician? ----------	___	___
If so, what condition is being treated? _____		
Physician name _____ Phone _____		
3. Have you ever been hospitalized/had any surgery/procedures or had a serious illness? ----------	___	___
If yes, explain (list dates) _____		
4. If yes, Do any of the above surgeries/procedures require you to take a pre-medication prior to dental treatment?	___	___
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?----------	___	___
6. (Women) Are you nursing ___ or pregnant___? If yes, give due date. _____	___	___
7. Do you use tobacco in any form? If yes, how much? _____	___	___
8. Do you use alcoholic beverages? If yes, more than 2 drinks per day? _____	___	___

Do you have or have you ever had any of the following? Check all that apply.

GENERAL
___Sleep Apnea
___Tire easily, weakness
___Marked weight change
___Night sweats
SKIN
___Eruptions (rash/hives)
___Change in skin color
EYES
___Visual change
___Glaucoma
EARS
___Ringing in ears
NOSE
___Frequent nose bleeds
___Sinus problems
BONE/MUSCLE
___Arthritis/rheumatism
___ Artificial joints/limbs
Date of replacement surgery_____

NERVOUS SYSTEM
___Stroke
___Headache
___Convulsion/epilepsy
___Numbness/tingling
___Dizziness/fainting
___Psychiatric treatment
___Multiple Sclerosis
___Parkinson's
RESPIRATORY
___Tuberculosis
___Emphysema
___Asthma/hay fever
___Persistent cough
ENDOCRINE
___Diabetes
___Thyroid condition/goiter
___Other_____
THROAT
___Swollen glands
___Soreness/hoarseness

HEART/BLOOD VESSELS
___Rheumatic fever
___Heart murmur
___Chest pain/discomfort
___Heart attack/trouble
___Shortness of breath
___Swelling of ankles
___High blood pressure
___Cholesterol **High/Low**
___Congenital heat disease
___Mitral valve prolapse
___Artificial heart valve
___Pacemaker
___Heart surgery
___Other_____
DIGESTIVE SYSTEM
___Hepatitis
___Jaundice
___Ulcers
___Change in appetite

URINARY
___Kidney disease
___Increase in frequency of urination (night)
___Venereal disease
___ Dialysis
BLOOD
___Bruise easily
___Anemia
___Blood transfusion
OTHER
___Radiation treatment
___Chemotherapy
___Tumors or growths
___Cancer
___HIV positive
___AIDS
___Organ transplant
___Other, please explain
_____

Are you ALLERGIC or have you ever experienced any reaction to the following?

___Local anesthetics (eg Novocain)
___Barbiturates/sedatives/sleeping pills
___Latex
___Aspirin or Codeine
___Sulfa Drugs
___Penicillin
Other Antibiotics_____
_____
Other Allergies_____

Are you taking any of the following medications?

___Antibiotics
___Blood thinners
___Blood pressure medication
___Thyroid medicine
___Cortisone/steroids
___Antihistamines/Allergy medications/Cold remedies
___Tranquilizers/Anti-Depressants
___Insulin/Other Diabetes medications
___Recreational drugs
___Digitalis/Other Heart medication
___Nitroglycerin
___Aspirin
___Other Medication(s) _____

List name(s) of medication and dosage:_____

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do?_____ If yes, explain. _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment

Signature of Patient, Parent or Guardian_____ Date_____

Dentist Signature_____ Date_____