HEALTH HISTORY

Patient's name ______________________________
Describe your health in general ______________________________
Date of last physical exam ______________ Dr.'s Name ______________
Have you ever had a serious illness? ______________ Yes No
Are you taking any drugs or medication now or within last 3 months? Yes No
If *Yes*, Please list ______________________________
Are there any drugs or substances you are allergic to or cannot tolerate? Yes No
If *Yes*, Please list ______________________________

Do you have or have you ever been told you have: Circle Yes or No

High Blood Pressure	Yes No	Taken Bisphosphonates	Yes No
Heart Murmur	Yes No	Cardiac Pacemaker	Yes No
Rheumatic Fever	Yes No	Joint Replacement	Yes No
Mitral Valve Prolapse	Yes No	Excessive Bleeding	Yes No
Hepatitis A B C / Jaundice	Yes No	Diabetes	Yes No
Immunosuppressive Disorder / HIV / AIDS	Yes No	Taken Phen-fen or Redux	Yes No
Liver Disease	Yes No	Heart Disease	Yes No
Kidney Disorder	Yes No	Seizure Disorder	Yes No
Venereal Disease	Yes No	Stomach Ulcers	Yes No
Stroke	Yes No	Asthma / Respiratory Problems	Yes No
Glaucoma	Yes No	Radiation Treatment	Yes No
Tuberculosis	Yes No	Cancer / Growths	Yes No
Allergic to Latex	Yes No	**Others** (*list below*):	
Blood Disorder	Yes No		

Women:

A) Are you pregnant or think you may be pregnant? Yes No
B) Are you taking Oral Contraceptives? Yes No

Have you ever had any unfavorable reaction from local anesthetic? Yes No
Have you ever had any serious trouble with previous dental treatment? Yes No
If *Yes*, please explain ______________________________
Any other disease, condition, or problem that we should know about? Yes No
If *Yes*, please explain ______________________________

To the best of my knowledge, all the preceeding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist immediately. Permission is hereby granted to the dentist to perform any dental work I need. To keep you comfortable during treatment, you may receive a local anesthetic.

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Patient's Signature Date
(Parent, if minor)

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Reviewed by Date
(Staff use only)