Health History

Patient Name:____ Date:____________

Are you in good health?____

Are you taking any medication:______If yes, please list:________________________

____

____

Have you been hospitalized in the last 10 years?______________________________

When was your last physical?_____________Physicians Name:__________________

Do you smoke/chew tobacco?_____________Physicians Phone #_________________

Do you have or are you being treated for:

Y N Allergies to medication _________________________________
Y N Reactions to Local Anesthetics _________________________________
Y N Allergies/Reactions to Antibiotics _________________________________
Y N Asthma, Hay fever or other allergies _________________________________
Y N Cancer: Radiation or Chemotherapy ________________________________
Y N Liver Disease _________________________________
Y N Kidney Disease _________________________________
Y N Heart Disease _________________________________
Y N Stroke _________________________________
Y N High Blood Pressure _________________________________
Y N Heart Murmur _________________________________
Y N Excessive Bleeding _________________________________
Y N Diabetes / Hypoglycemia _________________________________
Y N Epilepsy or Seizures _________________________________
Y N Rheumatic Fever _________________________________
Y N Hepatitis A – B – C _________________________________
Y N Tuberculosis / Lung Disease _________________________________
Y N Are you Pregnant _________________________________
Y N Have you donated blood in the last 10 years
Y N Have you been tested for HIV________Date:__________________________
Y N Do you have any reason to think you are HIV positive?___________________
Medication:___________________________
Y N Do you have any prosthesis? _________________________________
(Artificial Joints, Heart valves – pacemaker or pins)
Y N Depression Therapy _________________________________
Y N Alcohol or Drug related Therapy _________________________________
Y N Pre-Medication Necessary for a Dental Appointment____Type:_____________

I certify that the above information is current and correct and that I will notify this office of any changes.

Patients Signature:____ Date:_____________

Dentists Signature:____ Date:_____________