HEALTH HISTORY

YES NO

_____ _____ Are you in good health?
_____ _____ Has there been any change in your general health within the past year? If yes, explain_____
_____
My last physical exam was on _____
_____ _____ Are you under the care of a physician? If yes, what is the condition being treated?_____
_____
_____ _____ Have you had any serious illness or operation? If yes, what was the illness or operation?_____
_____
_____ _____ Are you taking any drug or medicine? If yes, please list_____
_____
_____ _____ Have you had excessive bleeding requiring special treatment?
_____ _____ Have you had any adverse drug reaction? Explain_____
_____ _____ Do you smoke?

ARE YOU ALLERGIC TO:
_____ _____ Local anesthetics (for example - novocaine or lidocaine)?
_____ _____ Penicillin or other antibiotic?
_____ _____ Sulfa drugs?
_____ _____ Barbiturates, sedatives, sleeping pills?
_____ _____ Codeine?
_____ _____ Aspirin?
_____ _____ Other drugs? If yes, please list_____
_____ _____ Do you have any other allergies?

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS:
_____ _____ Rheumatic Fever?
_____ _____ Heart disease or heart murmur?
_____ _____ Any heart prosthesis (pacemaker, heart valves)?
_____ _____ Stroke?
_____ _____ Diabetes?
_____ _____ High or low blood pressure?
_____ _____ Liver or kidney disorders (hepatitis, nephritis)?
_____ _____ Respiratory disorders (tuberculosis, asthma, hay fever)?
_____ _____ Sinus problems?
_____ _____ Arthritis?
_____ _____ Artificial joints?
_____ _____ Anemia?
_____ _____ Hives or skin rash?
_____ _____ Nervous disorders or psychiatric care?
_____ _____ Epilepsy?
_____ _____ Fainting spells or seizures?
_____ _____ Stomach ulcers?
_____ _____ Cancer?
_____ _____ Alcoholism or drug addiction?
_____ _____ Sexually transmitted diseases (Syphilis, Gonorrhea, Herpes)?
_____ _____ AIDS or other immunosuppressive disorders?
_____ _____ Have you ever had a blood transfusion? If so, when_____
_____ _____ Do you have any disease, condition, or problem not listed above that we should know about? If yes, explain_____
_____

WOMEN
_____ _____ Are you pregnant? If yes, due date is_____
_____ _____ Are you taking birth control pills or other hormonal therapy?
_____ _____ Osteopenia or Osteoporosis?

In the future please inform us of any change in your medical history, address, or phone number.

Please list the names of individuals you permit us to discuss your dental treatment: _____

_____

I certify that I have read and understand the above. 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.

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Patient's Signature_____Date_____