Health History

Name:	Date of Birth:	Today's Date:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Email Address:

Emergency Contact:	Home Phone: ( )	Cell Phone: ( )

Pharmacy:

Insurance Company:	Subscriber Name & Date of birth:	ID Number:	Group Number:

Medical History

Are you under the care of a physician? Y/ N	Have you been hospitalized in the last 5 years? Y/N
Physician's Name:_____ Phone: ( )_____ Address:_____	If Yes, what was the illness or problem?
Are you in good health? Y/N Any changes to your health in the last year? Y/N	Date of last physical exam:

Allergies, are you allergic to or have you had a reaction to:

Local Anesthetics	Y/N	Animals	Y/N
Aspirin	Y/N	Food	Y/N
Sulfa Drugs	Y/N	Other	Y/N
Hay fever/ seasonal	Y/N	Metals	Y/N
Codeine / other narcotics	Y/N	Latex	Y/N
Penicillin or other antibiotics	Y/N	Iodine	Y/N
Barbiturates, sedatives, sleeping pills	Y/N		

Health History

Do you wear contact lenses? Y/N	Do you use controlled substances? Y/N
Joint Replacements; Have you had any orthopedic total joint replacements? (elbow, knee, hip, finger, shoulder) Y/N Joint replaced: _____ Date: _____ Surgeon: _____ Phone: _____	**Women ONLY** are you: Pregnant _____ Y/N Number of weeks _____ Taking birth control pills _____ Y/N Nursing _____ Y/N

Artificial Heart Valve Y/N	Rheumatic Fever Y/N	Bronchitis Y/N	Neurological disorders Y/N
Angina Y/N	Rheumatic heart disease Y/N	Emphysema Y/N	
Arteriosclerosis Y/N	Abnormal Bleeding Y/N	Sinus Trouble Y/N	Specify:_____
Congestive Heart Failure Y/N	Anemia Y/N	Tuberculosis Y/N	
Damaged Heart Valves Y/N	Blood Transfusion Y/N	Chemotherapy Y/N	Mental health disorder Y/N
Heart Attack Y/N	Date:_____	Radiation treatment Y/N	
Heart Murmur Y/N	Hemophilia Y/N	Chest pain upon exertion Y/N	Specify: _____
Low Blood Pressure Y/N	AIDS or HIV infection Y/N	Chronic Pain Y/N	
High Blood pressure Y/N	Arthritis Y/N	Diabetes type I or II Y/N	Recurrent infection Y/N
Cardiovascular disease Y/N	Autoimmune disease Y/N	Eating disorder Y/N	
Congenital Heart Defects Y/N	Rheumatoid arthritis Y/N	Thyroid problem Y/N	Specify: _____
Specify _____	Systemic Lupus erythematosus Y/N	Gastrointestinal disease Y/N	Cancer Y/N
		G.E. Reflux/ heartburn Y/N	
Mitral valve prolapse Y/N	Asthma Y/N	Ulcers Y/N	Specify:_____
Pacemaker Y/N	Stroke Y/N	Do you snore Y/N	
Hepatitis, Jaundice Y/N	Glaucoma Y/N	excessive urination Y/N	Severe headaches or migraines Y/N
liver disease Y/N	Epilepsy Y/N	rapid weight loss Y/N	
Kidney problems Y/N	Fainting spells Y/N	Tobacco use Y/N	sexually transmitted diseases Y/N
Night sweats Y/N	Seizures Y/N		
Osteoporosis Y/N	Alcohol use Y/N		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y/N

Name of physician or dentist making recommendation:
Phone: ( )

Do you have a disease, condition or problem not listed above that we should know about? Y/N
Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions if any about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form

_____ _____
Patient Signature Date