HEALTH HISTORY

Patients Name:

Place a mark on 'Yes' or 'No' to indicate if you have had any of the following:

AIDS	□ Yes □ No	Epilepsy	□ Yes □ No	Psychiatric Care	□ Yes □ No
Anemia	□ Yes □ No	Fainting or dizziness	□ Yes □ No	Radiation Treatment	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	Glaucoma	□ Yes □ No	Respiratory Disease	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Headaches	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Artificial Joints	□ Yes □ No	Heart Murmur	□ Yes □ No	Scarlet Fever	□ Yes □ No
Asthma	□ Yes □ No	Heart Problems	□ Yes □ No	Shortness of Breath	□ Yes □ No
Back Problems	□ Yes □ No	Hepatitis	□ Yes □ No	Sinus Trouble	□ Yes □ No
Bleeding Abnormally, with		Type _____		Skin Rash	□ Yes □ No
extractions or surgery	□ Yes □ No	Herpes	□ Yes □ No	Special Diet	□ Yes □ No
Blood Disease	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Cancer	□ Yes □ No	HIV Positive	□ Yes □ No	Swelling of Feet or	
Chemical Dependency	□ Yes □ No	Jaundice	□ Yes □ No	Ankles	□ Yes □ No
Chemotherapy	□ Yes □ No	Jaw Pain	□ Yes □ No	Swollen Neck Glands	□ Yes □ No
Circulatory Problems	□ Yes □ No	Kidney Disease	□ Yes □ No	Thyroid Problems	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	Liver Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Cortisone Treatments	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Tuberculosis	□ Yes □ No
Cough, persistent or		Mitral Valve Prolapse	□ Yes □ No	Tumor or growth on	
Bloody	□ Yes □ No	Nervous Problems	□ Yes □ No	head or neck	□ Yes □ No
Diabetes	□ Yes □ No	Pacemaker	□ Yes □ No	Ulcer	□ Yes □ No
Emphysema	□ Yes □ No	Women:		Venereal Disease	□ Yes □ No
Blood Thinner		Are you pregnant ?	□ Yes □ No	Weight Loss,	□ Yes □ No
medication like asprin?	□ Yes □ No	Due date _____		unexplained	
		Are you nursing?	□ Yes □ No		

Previous Fosamax ,Boniva,Actonel or any cancer medications containing bisphosphonates use? □ Yes □ No

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin
□ Barbiturates
□ Codeine
□ Iodine
□ Latex
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ Other
_____
_____

Physician's Name and Phone #: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____ Dr's initial: _____

Updates (**To be filled in at future appointments**)

Has there been any change in your health since your last dental appointment? □ Yes □ No

For what conditions?_____

Are you taking any new medications?_____ If so_____

Patient initial_____Date_____ Doctor's initial_____Date_____

Patient initial_____Date_____ Doctor's initial_____Date_____

Patient initial_____ Date_____ Doctor's initial_____Date_____