NAME: _____ **~HEALTH HISTORY FORM~**

DATE OF BIRTH: _____ OCCUPATION: _____

ADDRESS: _____

PHONE_____SOCIAL SECURITY #: _____

FULL TIME STUDENT: YES/NO COLLEGE: _____

MEDICAL INFORMATION:

Are you currently under the care of a physician? Yes No

Physician's Name: _____ City, State: _____Phone: _____

Are you in Good Health? Yes No

Has there by any change in your health within the past year? Yes No

If yes, what are you being treated for: _____

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? _____

Do you have any of the following diseases or problems?

Active Tuberculosis:	Yes	No
Persistant Cough greater than 3 wks:	Yes	No
Cough that produces Blood	Yes	No
Been Exposed to anyone with tuberculosis:	Yes	No

Are you taking or schedule to begin taking:

Alendronate (Fosamax)	Yes	No
Risedronate (Actonel)	Yes	No
Intravenous Bisphosphonates (Aredia/Zometa)	Yes	No
Blood Thinners (Coumadin)	Yes	No

Are you taking or have you recently taken any prescription or over the counter medicines? Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____ _____

_____ _____

Allergies:

Local Anesthetics	**Yes**	**No**	**Penicillin**	**Yes**	**No**
Aspirin	**Yes**	**No**	**Sedatives, sleeping pills, barbiturates:**	**Yes**	**No**
Sulfa drugs	**Yes**	**No**	**Codeine or other Narcotics**	**Yes**	**No**
Metals	**Yes**	**No**	**Latex (Rubber)**	**Yes**	**No**
Iodine	**Yes**	**No**	**Other:** _____		

Please indicate if you have:

Heart Murmur	**Yes**	**No**	**Mitral Valve Prolapse**	**Yes**	**No**
Artifical Heart Valves	**Yes**	**No**	**Rheumatic Fever**	**Yes**	**No**
Cardiovascular Disease	**Yes**	**No**	**High Blood/Low Blood Pressure**	**Yes**	**No**
AIDS or HIV Infection	**Yes**	**No**	**Asthma**	**Yes**	**No**
Diabetes Type I or II	**Yes**	**No**	**Gastrointestinal Disease**	**Yes**	**No**
Heartburn	**Yes**	**No**	**Thyroid problems**	**Yes**	**No**
Joint Replacement	**Yes**	**No**	**Kidney problems**	**Yes**	**No**
History of Seizures	**Yes**	**No**	**Pacemaker**	**Yes**	**No**
Hepatitis, jaundice or liver Disease	**Yes**	**No**	**Cancer**	**Yes**	**No**
			Autoimmune Disease	**Yes**	**No**

Any Medical Condition not listed: _____

Has any physician/dentist recommended that you take antibiotics prior to your dental treatment Yes No

WOMEN ONLY: Are you: Pregnant: Yes / No Number of weeks: _____

Taking Birth control pills: Yes / No Nursing: Yes / No

DENTAL INFORMATION:

Do your gums bleed when you brush or floss?	Yes	No	Is your mouth dry?	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No	Have you any periodontal treatments?	Yes	No
Have you had any previous problems associated with previous dental treatment?	Yes	No	Are you currently experiencing dental pain or discomfort?	Yes	No
Is your home water fluoridated?	Yes	No	Do you have any clicking, popping or discomfort in your jaw?	Yes	No
Do you brux or grind your teeth?	Yes	No	Have you ever had braces?	Yes	No
Have you ever had a serious injury to your head/mouth?	Yes	No	Do you wear Dentures/Partials	Yes	No
Do you use Tobacco products?	Yes	No	Age of dental appliance? _____		

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature of Patient: _____Date: _____

If you are completing this form for another person, what is your relationship to that person? _____

Emergency Contact: Name:_____Telephone: _____Relationship: _____

THIS FORM HAS BEEN REVIEWED BY: _____DATE:_____