

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____

Are you currently under the care of a physician? Yes No Physician's name: _____

Do you take a pre-medication prior to dental appointments? Yes No

Have you ever responded adversely to dental/medical treatment? Yes No

Have you ever had any of the following? (check all boxes that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug or Alcohol Addiction | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Joints, screws, etc. | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Problems (chronic pain) | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bariatric Surgery | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Bleeding Abnormalities | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cancer/Chemotherapy/Radiation | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Swollen Lymph Nodes |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney/Renal Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other _____ |

Do you have any ALLERGIES (including latex and food)? Yes (please list on second page) No

Are you taking any medications at this time (including vitamins and over the counter medications)?
 Yes (please list *name* and *dosage* on second page) No

Have you ever taken any of the group of drugs known as bisphosphonates? (These include Zometa (zolendronate), Actonel (risedronate), Fosamax (alendronate), Boniva (abondronate), Nerixia (neridronate), Aredia (pamidronate)) Yes No

Do you currently use tobacco? Yes No
(if checked yes above) Type: _____ How often: _____

(Women) Do you suspect that you are pregnant? Yes No Due Date _____

Are you nursing? Yes No Are you taking birth control pills? Yes No

(Child) What is his/her weight? _____

Is there anything we should know about your health that would assist us in providing your dental care? _____

CERTIFICATION

The information given about my health and dental histories on this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient, parent, or guardian

Date

Printed name of parent of guardian

Relationship to patient

Allergies (including latex and food):

Medications, including vitamins and over the counter medications (name and dosage):
