PATIENT'S HEALTH HISTORY

AGE _____ WEIGHT _____

NAME _____ BIRTHDATE _____

Circle One

1. Are you in good health? ..... Yes No
2. Have you been a patient in a hospital during the past two years ..... Yes No
3. Are you now, or have you been, under a physician's care during the past two years? ..... Yes No
   a. If so, what was the condition you were treated for? _____
   b. Physician's name? _____
4. Are you taking any medication or under doctor's orders at the present time? ..... Yes No
   If so, what? (name of each drug) _____
   _____
   _____
5. Have you had a recent cough or cold? ..... Yes No
6. Are you taking any of these drugs (in the last six months) Coumadin, Anticoagulants, blood thinner, Steroids, Cortisones, Heart Medicine? ..... Yes No
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... Yes No
8. Have you experienced any unfavorable reaction from any previous dental treatment? ..... Yes No
9. Are you having pain or discomfort at this time? ..... Yes No
10. Have you ever had periodontal (gum) examination or surgery? ..... Yes No
11. Circle any of the following conditions you may have had:

AID - ARC	Emphysema	Lung Disease
Anemia	Excessive Bleeding	Pacemaker
Allergies	Genital Herpes	Pain in Jaw joint
Angina Pectoris	Fainting	Prosthetic Devices
Ankle Swelling	Glaucoma	Psychiatric Treatment
Asthma	Gonorrhea	Rheumatic Fever
Blood Transfusion	Heart Disease	Sickle Cell Disease
Chemotherapy	Heart Murmur	Sinus Trouble
Chest Pain	Heart Surgery	Scarlet Fever
Chronic Cough	Hemophilia	Stroke
Cold Sores	Hepatitis A (infectious)	Tuberculosis (TB)
Contact Lenses	Hepatitis B (Serum)	Thyroid Disease
Diabetes	High Blood Pressure	Ulcers
Dizziness	Jaundice	Venereal Disease
Drug Addiction	Kidney Disease	X-Ray or Cobalt Treatment
Epilepsy	Liver Disease	

Do you have any disease, condition or problem not listed? ..... Yes No

12. **WOMEN**: Are you pregnant now? ..... Yes No
    Are you practicing birth control? ..... Yes No
    Do you anticipate becoming pregnant? ..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change. I will inform the doctor of dentistry at the next appointment without fail.

ANNUAL UPDATE		
Any Change	Initial	Date

_____
Signature of Patient, Parent or Guardian

Date _____