PATIENT HEALTH HISTORY

Please answer each question. Circle **Yes** or **NO**

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Date of last physical examination? ______
3. Physician Name: ______
   Address ______ Phone ______
4. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ______
5. Have you ever had any serious illness or operation? .... Yes No
   If so, what illness or operation? ______
6. Have you ever been hospitalized? .... Yes No
   If so, what was the problem? ______
7. Are you taking any medicine? .... Yes No
   If so, what? ______
   Or any recreational drugs (marijuana, cocaine, etc.)? .... Yes No
8. Have you ever been pre-medicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs? .... Yes No
   ❑ Penicillin ❑ Tetracycline ❑ Sulfa Drugs ❑ Aspirin ❑ Codeine
   ❑ Other ______

10. Do you have or have you had any of the following: **Please check Yes or No (Y/N) for every condition.**

Y / N	Y / N	Y / N	Y / N	Y / N
❑ ❑ Anemia	❑ ❑ Rheumatism	❑ ❑ Sinus Trouble	❑ ❑ Cortisone Medicine	❑ ❑ X-Ray or Cobalt
❑ ❑ Hemophilia	❑ ❑ Heart Murmur	❑ ❑ Drug Addiction	❑ ❑ Excessive Bleeding	❑ ❑ Fainting Spells or Seizures
❑ ❑ Blood Disease	❑ ❑ Heart Failure	❑ ❑ Kidney Disease	❑ ❑ HIV Positive	❑ ❑ Chemotherapy (Cancer, Leukemia)
❑ ❑ Stroke	❑ ❑ Heart Surgery	❑ ❑ Stomach Ulcers	❑ ❑ Pain in Jaw Joints	❑ ❑ Radiation Treatment of any kind
❑ ❑ Herpes	❑ ❑ Heart Ailments or Attack	❑ ❑ Angina Pectoris	❑ ❑ Respiratory Disease	❑ ❑ Hepatitis or Jaundice
❑ ❑ Ulcers	❑ ❑ High Blood Pressure	❑ ❑ Mental Disorder	❑ ❑ Sickle Cell Disease	❑ ❑ Venereal Disease (Syphilis, Gonorrhea)
❑ ❑ Diabetes	❑ ❑ High Cholesterol	❑ ❑ Rheumatic Fever	❑ ❑ Tuberculosis (T.B.)	❑ ❑ AIDS (Acquired Immune Deficiency Syndrome)
❑ ❑ Glaucoma	❑ ❑ Cardiac Pacemaker	❑ ❑ Thyroid Disease	❑ ❑ Epilepsy or Seizures	❑ ❑ TMJ (Temporomandibular joint)
❑ ❑ Arthritis	❑ ❑ Bruise Easily	❑ ❑ Cerebral Palsy	❑ ❑ Artificial Prosthesis	❑ ❑ Hearing Impaired
❑ ❑ Emphysema	❑ ❑ Head Injuries	❑ ❑ Joint Replacement	❑ ❑ Psychiatric Treatment	❑ ❑ Latex or Metal Allergy
❑ ❑ Hay Fever	❑ ❑ Liver Disease	❑ ❑ Nervous Disorders	❑ ❑ Congenital Heart Lesions	❑ ❑ Asthma
❑ ❑ Tonsillitis	❑ ❑ Scarlet Fever	❑ ❑ Tumors or Growths	❑ ❑ Difficulty in Swallowing	❑ ❑ Contact Lenses
❑ ❑ Cold Sores	❑ ❑ Mitral Valve Prolapse	❑ ❑ Allergies or Hives	❑ ❑ Blood Transfusions	❑ ❑ Other ______

11. Do you have any disease, condition or problem not listed that you think I should know about? .... Yes No
    If so, what? ______
12. Have you ever taken Phen-Fen or other diet aids? .... Yes No
    If so, what? ______
13. (Women) Is there a possibility you may be pregnant? .... Yes No
14. Do you smoke, or use any tobacco products? Yes No How much? ______
15. (Women) Do you have any problems associated with your menstrual period? .... Yes No
16. (Women) Do you take birth control pills? .... Yes No

DENTAL HISTORY

1. Previous Dentist ______
   City ______
2. How long since your last dental x-rays and treatment? ______
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
4. Have you been having any specific problem? .... Yes No
   Explain: ______
5. Does dental treatment make you nervous? .... Yes No
   If so, check: ❑ Slightly ❑ Moderately ❑ Severely
6. Do you have, or have you had any of the following: .... Yes No
   (Please check known conditions) ❑ Bad Breath ❑ Loosening of Teeth
   ❑ Headaches ❑ Bleeding Gums ❑ Sensitive Teeth
   ❑ Jaws "Pop" or "Lock" ❑ Sinus Trouble
7. Have you ever had any of the following? .... Yes No
   ❑ Injury ❑ Oral Surgery ❑ Orthodontics ❑ Periodontics
   Explain: ______
8. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
9. Would you desire to be pre-sedated? .... Yes No
   ❑ Nitrous Oxide ❑ Drugs ❑ Or ______

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 medications change, I will, without fail, inform the doctor at my next appointment.

PATIENT, PARENT/GUARDIAN Signature: ______ Date: ______

DENTIST Signature: ______ Date: ______

CHANGES IN HEALTH

DATE	NOTE CHANGES	PATIENT SIGNATURE