

HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral healthcare. Please answer each question. This information is confidential.

NAME _____ AGE _____ HEIGHT _____ WEIGHT _____

MEDICAL HISTORY: please check one where applicable

1. Physician's name (your M.D. not your dentist) _____ Address _____ Phone _____
2. Are you in good health? _____ yes _____ no _____ Date of your last complete physical examination? _____
3. Are you under the care of a physician? _____ yes _____ no _____ if yes, for what condition? _____
4. Have you ever had any serious illness or operation? _____ yes _____ no _____ if yes, what illness or operation _____
5. Have you ever been hospitalized? _____ yes _____ no _____ if yes, what was the problem? _____
6. Are you taking any medication? _____ yes _____ no _____ if yes, what medication? _____ dosage? _____
7. Do you use any recreational drugs (marijuana, cocaine, etc.)? _____ yes _____ no _____ if yes, what drug _____ dosage? _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment _____ yes _____ no _____
9. Are you allergic to any of the following?

Local anesthetic("Novocaine")	yes _____ no _____	Asprin	yes _____ no _____	Penicillin	yes _____ no _____	Tranquilizers	yes _____ no _____
Nitrous Oxide	yes _____ no _____	Darvon	yes _____ no _____	Erythromycin	yes _____ no _____	Antidepressants	yes _____ no _____
Ibuprofen ("Motrin")	yes _____ no _____	Codeine	yes _____ no _____	Tetracycline	yes _____ no _____	Barbiturates	yes _____ no _____
Latex	yes _____ no _____						
10. Are you aware of being allergic to any other medication or substance that is not listed above? _____ yes _____ no _____ if yes, please describe: _____
11. Have you had or have at present, any of the following? **Please circle yes or no**

Mitral valve prolapse	yes _____ no _____	Anemia	yes _____ no _____	Cancer/Tumor	yes _____ no _____	Liver or Kidney Disease	yes _____ no _____
Heart Failure	yes _____ no _____	Stroke	yes _____ no _____	Radiation Treatment	yes _____ no _____	Yellow Jaundice	yes _____ no _____
Heart Disease or Attack	yes _____ no _____	Jaw pain	yes _____ no _____	Chemotherapy	yes _____ no _____	Drug addiction	yes _____ no _____
Angina pectoris	yes _____ no _____	Emphysema	yes _____ no _____	Arthritis/Rheumatism	yes _____ no _____	Blood Transfusion	yes _____ no _____
High blood pressure	yes _____ no _____	Tuberculosis	yes _____ no _____	Cortisone medicine	yes _____ no _____	Hemophilia	yes _____ no _____
Heart murmur	yes _____ no _____	Asthma	yes _____ no _____	Glaucoma	yes _____ no _____	Excessive bleeding	yes _____ no _____
Rheumatic fever	yes _____ no _____	Cold sores	yes _____ no _____	Bruise easily	yes _____ no _____	STD's(herpes, VD, etc)	yes _____ no _____
Artificial heart valve	yes _____ no _____	Sinus trouble	yes _____ no _____	Epilepsy/Seizures	yes _____ no _____	Allergies or hives	yes _____ no _____
Heart pacemaker	yes _____ no _____	Diabetes	yes _____ no _____	Stomach ulcers	yes _____ no _____	Artificial joints	yes _____ no _____
Heart surgery	yes _____ no _____	Hepatitis A	yes _____ no _____	Fainting or dizziness	yes _____ no _____	Nervous disorders	yes _____ no _____
Thyroid disease	yes _____ no _____	Hepatitis B	yes _____ no _____	AIDS/ARC/HIV	yes _____ no _____		
12. Do you have or have you ever had any disease, condition illness or problem not listed? _____ yes _____ no _____ If so, please describe _____
13. Do you smoke/use tobacco products? _____ yes _____ no _____ If yes, how much? _____ Do you have metal sensitivity _____ yes _____ no _____
14. Have you ever used Fen-Phen? _____ If yes, when? _____

FOR WOMEN ONLY:

14. Are you pregnant? _____ yes _____ no _____, If so, what is your due date? _____
15. Are you breast feeding now? _____ yes _____ no _____
16. Do you take birth control pills? _____ yes _____ no _____
17. Do you have or had breast implants? _____ if yes, when? _____

DENTAL HISTORY:

- Have you ever had a local anesthetic (Novocaine, etc.) _____ yes _____ no _____
- Have you had any serious trouble associated with any previous dental treatment? _____ yes _____ no _____ if yes please explain _____
- When was your last full mouth x-rays? _____ How long since your last dental treatment? _____
- Does dental treatment make you nervous? _____ yes _____ no _____ if yes, please check one, slightly _____ moderately _____ extremely _____
- Do you desire to be pre-sedated? _____ 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 medications change, I will, without fail, inform the doctor at my next appointment.

CONSENT:

I hereby authorize the dentist, to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I hereby grant authority to the dentist to administer such anesthetics, sedatives, nitrous oxide sedation, and to perform such operations as may be necessary or advisable in the diagnosis and treatment of this patient.

Signature _____ Date _____ Relationship to patient _____

Dentist signature _____ Date _____ Witness _____

UPDATE

Date _____	Date _____	Date _____	Date _____
Changes _____	Changes _____	Changes _____	Changes _____
Signature _____	Signature _____	Signature _____	Signature _____