HEALTH HISTORY

PATIENT NAME: _____ **ACCOUNT #:** _____

To be completed with patient's information only. Please answer every question and circle Y or N where applicable.

Are you in good health? **Y N**
Are you under the care of a physician? **Y N**
If so, what is the condition being treated? _____
Physician name:_____ Phone No:_____
Address:_____
City:_____ State: _____Zip:_____
Have you ever had a serious illness or operation? **Y N**
If so, what illness or operation? _____

Date of last physical examination: _____/_____/_____
Have you ever been hospitalized? **Y N**
If so, why? _____
Are you taking any medication? **Y N**
If so, what?_____ Dosage:_____
Are you using any recreational drugs (marijuana, etc.)? **Y N**
If so, what?_____
Frequency:_____

Have you ever had any disease, medication, or transplant operations that have depressed your immune system? **Y N**
Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or cancer (i.e. Reclast, Fosamax, Actonel, Boniva, etc.)? **Y N**
Have you ever been premedicated with antibiotics for dental treatment? **Y N**
Do you have any allergies? If yes, to what? _____ **Y N**

❑ Latex ❑ Penicillin ❑ Tetracycline ❑ Sulfa Drugs ❑ Aspirin ❑ Codeine ❑ Other:_____

Do you have, or have you ever had any of the following (Please circle **Y** or **N**, answer all conditions):

Anemia **Y N**	Bruise Easily **Y N**	Tuberculosis (TB) **Y N**	Respiratory Disease **Y N**
Herpes **Y N**	Abnormal Bleeding **Y N**	Rheumatic Fever **Y N**	Epilepsy or Seizures **Y N**
Stroke **Y N**	Head Injuries **Y N**	Blood Transfusion **Y N**	Psychiatric Treatment **Y N**
Ulcers **Y N**	Autism **Y N**	Joint Replacement **Y N**	Hepatitis or Jaundice **Y N**
Diabetes **Y N**	Scarlet Fever **Y N**	Nervous Disorders **Y N**	Difficulty in Swallowing **Y N**
Glaucoma **Y N**	Sinus Trouble **Y N**	Tumors or Growths **Y N**	Heart Ailments **Y N**
Arthritis **Y N**	Heart Murmur **Y N**	Allergies or Hives **Y N**	Congenital Heart Lesions **Y N**
Hay Fever **Y N**	Liver Disease **Y N**	Pain in Jaw Joints **Y N**	Radiation, X-ray or Cobalt Treatment **Y N**
Tonsil Issues **Y N**	Blood Disorder **Y N**	Artificial Prosthesis **Y N**	Fainting Spells, Epilepsy or Seizures **Y N**
Asthma **Y N**	Drug Addiction **Y N**	Sickle Cell Disease **Y N**	Chemotherapy (Cancer, Leukemia) **Y N**
Hemophilia **Y N**	Kidney Disease **Y N**	Cortisone Medicine **Y N**	Treatment for Tumors/Growths (not X-ray Therapy) **Y N**
Cold Sores **Y N**	Stomach Ulcers **Y N**	Allergies to Metals **Y N**	ADD or ADHD **Y N**
Breathing Issues **Y N**	Angina Pectoris **Y N**	Excessive Bleeding **Y N**	Acquired Immune Deficiency Syndrome (AIDS) **Y N**
Rheumatism **Y N**	Mental Disorder **Y N**	High Blood Pressure **Y N**	TMJ (Temporomandibular Joint) Disorder **Y N**
Chicken Pox **Y N**	Cerebral Palsy **Y N**	Low Blood Pressure **Y N**	Impaired Vision, Hearing or Speech: _____ **Y N**
Osteoporosis **Y N**	Thyroid Disease **Y N**	HIV Related Complex **Y N**	Tobacco Products: _____ **Y N**

Is there anything you would like to discuss with the Doctor in private? **Y N**
Do you wear a prosthesis? _____ **Y N**
Have you had heart surgery? If so, when? _____ **Y N**
Have you ever been advised NOT to take a medication? **Y N**
If yes, what? _____ When?_____
Have you ever had local anesthetic (Novocaine, etc)? **Y N**
Have you ever had a reaction from local anesthetic? **Y N**
If yes, explain_____
How long since your last full mouth x-rays?
Weeks _____ Months _____ Years _____

Do you have any past history of alcohol/chemical dependency or emotional disorder that may affect the care we provide to you? **Y N**
Do you have a disease or condition not listed above? **Y N**
If yes, what?_____
Have you ever taken the drugs "Phen-Phen" or "Redux"? **Y N**
If yes, which one?_____ When?_____
Have you ever had excessive bleeding after your dental work? **Y N**
Have you ever had trouble associated with dental work? **Y N**
If yes, explain_____
How long since last dental treatment?
Weeks _____ Months _____ Years _____

Females:

Are you pregnant? **Y N**
If yes, how many weeks? _____
Any problems associated with menstrual cycle? **Y N**
Currently taking birth control pills? **Y N**

Comments:

_____

_____

I have filled out this questionnaire completely. I have advised you of all medical problems of which I am aware and I authorize and give full consent to perform dental services agreed between doctor and patient to be necessary or advisable, including examination, radiographs, local anesthetics and other medications as indicated. I am responsible for payment on all work performed regardless of my insurance coverage and hereby assign payment of my insurance benefits to the provider of services.

Signature: _____ Date: _____
If Minor, Parent or Legal Guardian

Doctor Signature: _____ Date: _____