HEALTH HISTORY

Patient Name: ____ DOB: ______/______/______

Have you ever been told to take antibiotics PRIOR to dental treatment due to health? Yes: ______ No: _______

If YES, please explain: ____

Please list any medications you are currently taking: ___________________________________

____

Do you currently or have you had any of the following conditions: (Please circle Yes or No)

Y / N	High Blood Pressure	Y / N	Cardiac Pacemaker	Y / N	Angina
Y / N	Mitral Valve Prolapse	Y / N	Jaundice	Y / N	Hay Fever
Y / N	Heart Conditions/Disease	Y / N	Epilepsy/Seizures	Y / N	Arthritis
Y / N	Coumadin Therapy	Y / N	Heart Murmur	Y / N	Fainting Spells
Y / N	HIV/AIDS	Y / N	Respiratory Problems	Y / N	Cancer
Y / N	Kidney/Liver Disease	Y / N	Prolonged Bleeding	Y / N	Anemia
Y / N	Tuberculosis/Lung Disease	Y / N	Venereal Disease(s)	Y / N	Asthma
Y / N	Artificial Joints/Implants:	Y / N	Rheumatic Fever	Y / N	Diabetes
	Knee /Hip/ Other: __________	Y / N	Hepatitis A/ B/ C	Y / N	Dizziness
Y / N	Dementia/ Alzheimer's	Y / N	Headaches/Migraines	Y / N	Sinus Problems
Y / N	Nervous Disorders	Y / N	Thyroid Disorders	Y / N	Stroke
Y / N	Other:				

Are you Allergic to any of the following? Y / N Penicillin Y / N Sulfa

Y / N Codeine Y / N Latex Y / N Aspirin Y / N Other:

Women ONLY: Are you pregnant or think you may be? Y / N Are you nursing? Y / N

Are you taking Birth Control Pills? Y / N

DENTAL HISTORY

Y / N	Do you feel any pain in any of your teeth?	Y / N	Do you clench or grind your teeth?
Y / N	Does dental treatment make you nervous?	Y / N	Do you like your smile?
Y /N	Have you ever had a "deep cleaning"?	Y / N	Would you like to know your cosmetic options?

When was your last dental visit? ____________ What are your dental priorities? ________________________

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AUTHORIZATION: I have reviewed this form and assure it is accurate to the best of my knowledge. If there is any change in my medical history I will notify the dentist and staff.

Patient/Guardian Signature: ____ Date: _____________

DDS Signature: ___________________ Comments : ____________________ Date: _____________

DDS Signature: ___________________ Comments : ____________________ Date: _____________