HEALTH HISTORY

It is important that we know about your medical and dental history. These facts have a direct bearing on your dental treatment.

What prompted you to seek dental care at this time? _____

When was your last dental examination? _____ Are any teeth sensitive to: hot? cold? sweet?

Are you nervous about having dental treatment? _____ Have you ever had a bleeding problem after treatment? _____

Do you clench or grind your teeth? _____ Do you have frequent headaches? _____

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Physician's Name: _____ Phone #: (____) ____-_____

Specialist's Name: _____ Specialty: _____ Phone #: (____) ____-_____

Are you under a doctor's care now? Yes ☐ No ☐ If yes, for what? _____

Have you been hospitalized in the last 2 years? Yes ☐ No ☐ If yes, for what? _____

Are you allergic to or have you reacted adversely to any of the following medications? If so, please circle.

Penicillin	Sulfa drugs	Local Anesthetic	Codeine	Other: _____
Amoxicillin	Erythromycin	Aspirin	Tetracycline	None

Do you take aspirin daily for your heart? Yes ☐ No ☐ **Women only:** Are you pregnant? Yes ☐ Due?_____ No ☐

Please list any medications you are taking. Be sure to include prescription medications, as well as any herbal or over-the-counter medications taken regularly: _____

Please circle any of the following which you have had or have at present:

Heart failure	Stroke	Liver disease	Hypoglycemia	Latex allergy
Heart attack	Anemia	Hepatitis A	Glaucoma	Lung disease
Artificial heart valve	Rheumatic fever	Hepatitis B	Alzheimer's disease	Arthritis
Open heart surgery	Shortness of breath	Hepatitis C	Psychiatric care	Gout
Heart murmur	Swelling of feet/ankles	HIV	Chemotherapy/Radiation	Frequent cough
Mitral valve prolapse	Fainting/dizzy spells	Epilepsy/Seizures	Cancer	Leukemia
High blood pressure	Low blood pressure	Thyroid disease	Ulcers	Tuberculosis
Angina pectoris	Diabetes	Kidney trouble	Allergies/Hay fever	Transfusion
Pacemaker	Artificial joints (hip, knee)	Parkinson's disease	Sinus trouble	Drug addiction
Congenital heart lesion	Asthma	Hemophilia	Sickle cell anemia	Emphysema

Have you ever had any other serious illness not circled above? Please describe: _____

Do you smoke or use tobacco products? Yes ☐ No ☐

Do you use recreational drugs? Yes ☐ No ☐ (Interactions may occur with anesthetics or other medications.)

Have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, Zometa, etc.)? Yes ☐ No ☐

Do you wish to speak to the doctor privately about any problem? _____

All information given on this form is correct to the best of my knowledge. I give permission for the dentist to discuss my medical condition with my physician and to request medical information from him/her.

Patient's signature (or parent if a minor): _____ **Date:** _____

History Updates: *I have reviewed the information contained on this form and certify that there have been no changes other than noted on this form, and that all other information is correct to the best of my knowledge.*

Initials:_____ **Date:** _____ **Initials:**_____ **Date:** _____ **Initials:**_____ **Date:** _____

_____ _____ _____ _____ _____ _____