HEALTH HISTORY

Name: _____

Does your doctor require you to take an antibiotic prior to dental treatment? Yes☐ No☐

Heart Problems Yes☐ No☐

- Chest pain
- Shortness of breath
- High/low blood pressure (circle one)
- Heart Murmur
- Heart valve problem
- Rheumatic fever
- Pacemaker
- Artificial heart valve

Please list all medications for the above conditions: _____

_____

Blood Problems Yes☐ No☐

- Easy bruising
- Frequent nosebleeds
- Abnormal bleeding
- Anemia
- Ever require a blood transfusion?
- High Cholesterol

Please list all medications for the above conditions: _____

_____

Allergy Problems Yes☐ No☐

- Hay fever
- Sinus problems
- Skin rashes
- Asthma

Please list all medications for the above conditions: _____

_____

Bone or Joint Problems Yes☐ No☐

- Arthritis
- Back or neck pain
- Artificial joint (hip, knee, implant)
- Osteoporosis

Please list all medications for the above conditions: _____

_____

Intestinal Problems Yes☐ No☐

- Ulcers
- Acid reflux
- Weight gain or loss
- Special Diet
- Constipation/diarrhea
- Kidney or bladder problems

Please list all medications for the above conditions: _____

_____

Diabetes Yes☐ No☐

- Urinate more than 6 times a day
- Thirsty or dry mouth much of the time
- Family history of diabetes

Please list all medications for the above conditions: _____

_____

Women Only

Are you pregnant? Yes☐ No☐

If yes, expected delivery date _____

Are you taking contraceptives or other hormones? Yes☐ No☐

Are you nursing? Yes☐ No☐

Have you reached menopause? Yes☐ No☐

If so, please describe symptoms _____

Dentist Signature Date

Other problems Yes☐ No☐

- Fainting spells, seizures, Epilepsy
- Stroke
- Frequent or severe headaches (migraine)
- Thyroid problems
- Persistent cough
- Swollen glands
- Tuberculosis or other respiratory disease
- Hepatitis, jaundice, or liver trouble
- Herpes or other STD
- HIV positive/AIDS
- Glaucoma
- History of head injury
- Cancer (History of tumor)
- Chemo/Radiation treatment

If yes, when _____

Please list all medications for the above conditions: _____

_____

Do you smoke? Yes☐ No☐

If yes, since when: _____ Frequency _____

Do you use chewing tobacco? Yes☐ No☐

If yes, since when: _____ Frequency _____

Do you have any history of alcohol or drug abuse? Yes☐ No☐

If yes, when? _____

Do you have any disease, condition, or problem not listed previously that you feel we should know about? Yes☐ No☐

If yes, please describe: _____

_____

_____

During the past 12 months, have you taken any of the following?

- Antibiotics or sulfa drugs Yes☐ No☐
- Anticoagulants (Coumadin, etc.) Yes☐ No☐
- High blood pressure medicine Yes☐ No☐
- Insulin, Orinase, or similar drug Yes☐ No☐
- Aspirin Yes☐ No☐
- Antidepressant Yes☐ No☐
- Digitalis or drugs for heart trouble Yes☐ No☐
- Nitroglycerin Yes☐ No☐
- Cortisone (steroids) Yes☐ No☐
- Natural remedies Yes☐ No☐
- Non-prescription drugs/supplements Yes☐ No☐

If yes to any of the above conditions, please list below: _____

_____

_____

Are you allergic to or have you reacted adversely to any of the following:

- Local anesthetics (Novocain, etc.) Yes☐ No☐
- Penicillin or other antibiotics Yes☐ No☐
- Sulfa drugs Yes☐ No☐
- Barbiturates, sedatives, or sleeping pills Yes☐ No☐
- Aspirin, Acetaminophen, or Ibuprofen Yes☐ No☐
- Codeine, Demerol or other narcotics Yes☐ No☐
- Metals Yes☐ No☐
- Latex or rubber dam Yes☐ No☐
- Other_____ Yes☐ No☐

If yes to any of the above, please describe:_____

_____

_____

Patient/Parent Signature Date