## **HEALTH HISTORY**

Does your doctor require you to take a	n antibi	otic prior	
to dental treatment? Yes		No	Other problems Yes
to defital treatment:			Fainting spells, seizures, Epilepsy
Heart Problems	Yes□	No	Stroke
Chest pain			Frequent or severe headaches (migraine)
•	님	님	Thyroid problems
Shortness of breath	님	님	Persistent cough
High/low blood pressure (circle one)	닏	님	Swollen glands
Heart Murmur	닏	님	Tuberculosis or other respiratory disease
Heart valve problem	$\sqcup$	$\sqcup$	Hepatitis, jaundice, or liver trouble
Rheumatic fever	╚	$\sqcup$	Herpes or other STD
Pacemaker	$\sqcup$	$\sqcup$	HIV positive/AIDS
Artificial heart valve			Glaucoma
Please list all medications for the above conditions: $\_$			History of head injury
			Cancer (History of tumor)
Blood Problems	Yes□	No□	Chemo/Radiation treatment
	_	_	If yes, when
Easy bruising	$\sqcup$	$\sqcup$	
Frequent nosebleeds			Please list all medications for the above conditions:
Abnormal bleeding			
Anemia			D
Ever require a blood transfusion?			Do you smoke? YesL
High Cholesterol			If yes, since when: Frequency
Please list all medications for the above conditions: _			Do you use chewing tobacco? Yes
			If yes, since when: Frequency
Allergy Problems	Yes		Do you have any history of alcohol or drug abuse? Yes
Hay fever	$\sqcap$	ī	If yes, when?
Sinus problems	П	ī	Do you have any disease, condition, or problem not listed pr
Skin rashes	H	H	feel we should know about? Yes
Asthma	H	H	If yes, please describe:
Please list all medications for the above conditions: _	Ш	ш	
- rease list all medications for the above conditions.			
Bone or Joint Problems	Yes	No	De destile and 42 weather have a state of the fallow
Arthritis			During the past 12 months, have you taken any of the follow
Back or neck pain			Antibiotics or sulfa drugs Yes
Artificial joint (hip, knee, implant)			Anticoagulants (Coumadin, etc.) Yes
Osteoporosis			High blood pressure medicine Yes
Please list all medications for the above conditions: _	_	_	Insulin, Orinase, or similar drug Yes
			Aspirin Yes[
Intestinal Problems	Yes	No□	Antidepressant Yes
Ulcers			Digitalis or drugs for heart trouble Yes
Acid reflux	H	H	Nitroglycerin Yes[
	H	$\dashv$	Cortisone (steroids) Yes
Weight gain or loss	님	님	Natural remedies Yes
Special Diet	님	님	Non-prescription drugs/supplements Yes[
Constipation/diarrhea	닏	닏	If yes to any of the above conditions, please list below:
Kidney or bladder problems	Ш		if yes to any of the above conditions, please list below.
Please list all medications for the above conditions: _			
Diabetes	Yes	No	Assessable asia to as bases as a seated advantable to a fit
Urinate more than 6 times a day	Ш		Are you allergic to or have you reacted adversely to any of the
Thirsty or dry mouth much of the time			Local anesthetics (Novocain, etc.)  Yes
Family history of diabetes			Penicillin or other antibiotics Yes
Please list all medications for the above conditions: _			Sulfa drugs Yes
			Barbiturates, sedatives, or sleeping pills Yes
			Aspirin, Acetaminophen, or Ibuprofen Yes
Waman Only			Codeine, Demerol or other narcotics Yes
<u>Women Only</u>			Metals Yes[
Are you pregnant?	Yes	No	Latex or rubber dam Yes
If yes, expected delivery date	_		Other Yes[
Are you taking contraceptives or other hormones?	Yes□	No	If yes to any of the above, please describe:
Are you nursing?	Yes□	No□	ii yes to aily of the above, please describe.
Have you reached menopause?	Yes□	No□	
If so, please describe symptoms			
Dentist Signature	Date		Dationt/Datest Circulture
serios signature	Dute		Patient/Parent Signature

Name:		
Other problems	Yes□	No
Fainting spells, seizures, Epilepsy		
Stroke		
Frequent or severe headaches (migraine)	님	님
Thyroid problems	님	
Persistent cough Swollen glands	H	H
Tuberculosis or other respiratory disease	H	Ħ
Hepatitis, jaundice, or liver trouble		Ī
Herpes or other STD		
HIV positive/AIDS		
Glaucoma		
History of head injury	님	
Cancer (History of tumor)	님	님
Chemo/Radiation treatment  If yes, when		
Please list all medications for the above conditions:		
Do you smoke?	Yes□	No
If yes, since when: Frequenc	у	
Do you use chewing tobacco?	Yes	No
If yes, since when: Frequenc		
Do you have any history of alcohol or drug abuse?  If yes, when?	Yes∐	No
Do you have any disease, condition, or problem not lis	sted previo	usly 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 If yes to any of the above conditions, please list below	Yes∐ ,.	No.
Are you allergic to or have you reacted adversely to a	_	_
Local anesthetics (Novocain, etc.)	Yes∐	No∐
Penicillin or other antibiotics	Yes∐	No.
Sulfa drugs	Yes∐ Yes□	No∐ No□
Barbiturates, sedatives, or sleeping pills 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