HEALTH HISTORY

Name:____ Date of Birth:________________
Medical Alert:____

1. Have you **ever** had any of the following? (check boxes that apply)
   - ❐ Heart Problems
   - ❐ Blood Pressure Problems
   - ❐ Circulatory Problems
   - ❐ Mitrol Valve Prolapse
   - ❐ Artificial Valves or Joints
   - ❐ Heart Murmur
   - ❐ Rheumatic Fever
   - ❐ Stroke
   - ❐ Radiation Treatment
   - ❐ Cancer
   - ❐ Blood Disease
   - ❐ Special Diet past or present (like Fen-Phen)
   - ❐ Diabetes
   - ❐ Respiratory Disease
   - ❐ Tuberculosis
   - ❐ General Allergies
   - ❐ Sinus Problems
   - ❐ Hepatitis, Kidney or Liver Disease
   - ❐ Headaches
   - ❐ Epilepsy
   - ❐ Mental Illness
   - ❐ Jaw or Ear Pain
   - ❐ A.I.D.S / HIV
   - ❐ Ulcer
   - ❐ STD
   - ❐ Chemical Dependency
   - ❐ Arthritis
   - ❐ Other

	Yes	No
2. Are you under medical treatment now?	❐	❐
3. Are you now taking prescriptions drugs or medications? If so, what?	❐	❐
4. Have you had any major operations? If so, what? when?	❐	❐
5. Have you ever had a serious accident involving head injuries?	❐	❐
6. Are you allergic to any medications? If so, what?	❐	❐
7. Do you use tobacco of any kind?	❐	❐
8. Do you have significant fear of dentistry?	❐	❐
9. Have previous cuts healed slowly or presented other complications?	❐	❐
10. Are you pregnant or nursing? How many months?	❐	❐
11. Do you have a history of fainting?	❐	❐
12. Date of last physical		
13. Is there any other information that should be known about your health or previous dental visits?	❐	❐

14. Name of family physician_________________________________ Phone ____________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Today's Date ________________ Patient Signature____

UPDATES

Date	Initials	BP	Changes