HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Physician's Address _____

Please mark "Yes" or "No" to indicate if you have or had any of the following:

AIDS	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Women: Are you pregnant?	☐ Yes	☐ No
Alcohol use	☐ Yes	☐ No	Epilepsy/Seizures or Convulsions	☐ Yes	☐ No	Due date_____		
Anemia	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	Fever Blisters/Mouth Ulcers or Canker Sores	☐ Yes	☐ No	Prosthetic Replacement	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Hearing Problem	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Back Problem	☐ Yes	☐ No	Heart Problem	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bleeding abnormally, w/ extractions or surgery	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke/TIA	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	HIV+	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Circulatory Problem	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tobacco use	☐ Yes	☐ No
Congenital Heart Lesion	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor/Growth on Head/Neck	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No	Nervous Problem	☐ Yes	☐ No	Vision Problem/Glaucoma or Cataract	☐ Yes	☐ No
Drug/Alcohol rehabilitation	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Drug use (illegal)	☐ Yes	☐ No						

MEDICATIONS

List medications you are currently taking _____

_____

_____

Pharmacy's Name _____

Pharmacy's Phone _____

ALLERGIES

(Causing swelling, rash, hives, itching or difficulty breathing)

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine or other pain meds
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa
- ☐ Other Drugs_____

_____

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES. ANY OUTSTANDING BALANCE AFTER 30 DAYS MAY INCUR A FINANCE CHARGE OF 18% PER ANNUM OR 1-1/2% PER MONTH.

Signed _____ _____ _____

Patient, Parent or Guardian (Must be 18 years or older) Doctor Date

UPDATES (Every 6 months)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

If so, what _____

Are you taking any new medications? ☐ Yes ☐ No If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____