HEALTH HISTORY

Patient Name: _____

1. Name of Physician: _____ Phone: _____

2. Date of last physical examination _____

3. Are you in good health?..... □ Yes □ No

4. Have you had surgery or X-ray treatment for a tumor, growth and or other condition of the head, mouth, or lips?..... ……. □ Yes □ No

5. Are you under the care of a physician for any medical problems? ..... □ Yes □ No

6. Have you ever had any serious illness or major operations?..... □ Yes □ No

7. Are you taking any medications regularly? (Prescription or over the counter)..... □ Yes □ No
   If so, please list_____

8. Have you had an adverse reaction or allergy to any following?

   Aspirin ..... □ Yes □ No
   Dental anesthetics ..... □ Yes □ No
   Anti-inflammatory medications ..... □ Yes □ No
   Penicillin or other antibiotics ..... □ Yes □ No
   Codeine or other pain medications..... □ Yes □ No
   Latex materials..... □ Yes □ No

9. Are there any medications you cannot take?..... □ Yes □ No
   If so, please list_____

10. Have you ever had abnormal bleeding or difficulty with clotting after a wound? ..... □ Yes □ No

11. Have you ever had an unfavorable reaction following dental treatment? ..... □ Yes □ No

12. Do you smoke? ..... □ Yes □ No

13. Please fill in appropriate box if you have EVER had any of the following?

□Alcoholism/Drug Dependency	□Glaucoma	□Phen/fen
□Artificial joints/Prosthetic Implants	□Heart trouble of any kind	□Prosthetic cardiac valves
□Asthma	□Heart Murmur	□Radiation therapy
□Bacterial Endocarditis	□Hepatitis/Jaundice	□Rheumatic fever
□Bisphosphonates-Fosamax, Actonel, Boniva (Osteoporosis medication)	□High/low blood pressure	□Seizures or convulsions
	□HIV positive/Aids	□Stroke
□Cancer	□Kidney problems	□Syncope/ Tendency to faint
□Cardiovascular Disease	□Mitral valve prolapse	□Tuberculosis
□Diabetes	□Organ transplant	□Ulcers
□Emphysema	□Pacemaker	□Venereal Disease
□Epilepsy		

14. Have you any other serious illness?..... □ Yes □ No
    Please state: _____

15. Are you taking female hormones (oral contraceptives, etc.)?..... □ Yes □ No

16. Are you pregnant, trying to become pregnant or nursing at the present time?..... □ Yes □ No

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at subsequent appointments.

Date: _____ Patient Signature: _____

Update_____ Patient Signature: _____

Reviewed by: _____ Date: _____