Health History

Date_____

Patient's name_____ Date of Birth _____

Please circle YES or NO, whichever applies.
Your answers are for our records only and are considered confidential.

YES NO Do you consider yourself in good health at this time?
YES NO Have there been any changes in your general health in the last year?
YES NO Have you ever been instructed to take pre-medications before dental treatment?
YES NO Have you ever taken Phen-Fen or any other diet pills.

Do you have any of the following conditions?

YES NO Damaged heart valves, artificial valves, pacemaker, artificial arteries or grafts
YES NO History of Rheumatic Fever or Scarlet Fever
YES NO Congenital heart defect or heart murmur
YES NO Cardiovascular disease, heart attack, hypertension, stroke or cardiac insufficiency
YES NO Artificial joints or surgically placed prosthesis, including hip or knee joints
YES NO Low blood pressure or fainting
YES NO Seizures or epilepsy
YES NO Diabetes or blood sugar problems
YES NO Liver disease, history of jaundice or Hepatitis
YES NO Kidney disease or stomach ulcers
YES NO Tuberculosis or Asthma
YES NO History of smoking: Amount per day Number of years
YES NO Alcoholism, drug use or dependence
YES NO Psychotherapy or nervous conditions
YES NO History of bleeding problems, blood disorders or Anemia
YES NO Immune compromises, including HIV, ARC or AIDS
YES NO Have you ever had treatment for cancer including x-rays treatment or chemotherapy
YES NO Do you have any diseases, conditions or problems other than those listed above?
If Yes, please provide more detail.

_____

_____

Do you have any allergies or adverse reaction to any of the following medications?

YES NO Penicillin or other antibiotics
YES NO Aspirin or Ibuprofen
YES NO Sulfa drugs or Iodine
YES NO Codeine or other narcotic medications
YES NO Valium, Sedatives or sleeping pills
YES NO Have you or any blood relative had any adverse reactions to local or general anesthetic?
YES NO Other
If Yes, please provide more detail.

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_____

Please continue to page 2 of the Health History Form

Women:

YES NO Are you pregnant or possibly pregnant at this time
YES NO Are you currently a nursing mother

Are you currently taking any of the following medications?
Please list the medication and dosage:

YES NO Antibiotics
YES NO Anticoagulants (blood thinners)
YES NO Blood pressure medications.
YES NO Steroids
YES NO Tranquilizers or Antihistamines
YES NO Aspirin, Ibuprofen or Naproxen (Aleve)
YES NO Insulin, Tolbutamide (Orinase) or other blood sugar altering medications
YES NO Digitalis, Nitroglycerine or other heart medications
YES NO Oral contraceptives
YES NO Any other prescription medications

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

_____ _____

Signature of Patient (or legal guardian) **Date**