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Health History

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

1. Patient Information

Gender: Male ☐ Female ☐ *Marital Status*: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Patient Name _____ Name of Parent/Guardian (if minor) _____ Date of Birth _____ Age _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Social Security # _____ Alternate Phone _____ Emergency Contact Info (Name & Phone Number) _____

2. Health History Questionnaire

	Yes	No
A) Have you been treated by a physician (M.D.) within the last 2 years? Name of physician: _____	☐	☐
B) Have you ever had surgery on the Heart, Lungs, or Kidneys?	☐	☐
C) Have you taken any drugs or medications regularly during the last 6 months?	☐	☐
D) List Medications: _____		
E) Have you ever had a radiation treatment for cancer?	☐	☐
F) Please indicate if you are you allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____		
G) If yes, please explain: _____		
H) Have you ever had a problem with local anesthesia (numbness)?	☐	☐
I) Have you ever had any excessive bleeding requiring special treatment?	☐	☐
J) Do you, or have you ever had pain/clicking of the jaw joints?	☐	☐
K) Amount of alcohol intake:(check one) ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never		
L) Do you smoke? How many cigarettes per day? _____	☐	☐
M) Do you use chewing tobacco?	☐	☐
N) Have you ever used non-prescription "street drugs" (Heroin, LSD, etc.)?	☐	☐

3. Past or Present Conditions

Please check all the apply:

- ☐ Heart Murmur
- ☐ Tuberculosis
- ☐ Irregular Heartbeat
- ☐ Colitis
- ☐ Chronic Sinus/Hay Fever
- ☐ Rheumatic Fever
- ☐ Frequent Constipation
- ☐ Dizziness
- ☐ Pneumonia
- ☐ Syphilis
- ☐ Shortness of Breath
- ☐ Neck/Spine Problems
- ☐ Congestive Heart Failure
- ☐ Ulcers
- ☐ Arthritis
- ☐ Chest Pain/Angina
- ☐ Jaundice
- ☐ Blackouts
- ☐ Bronchitis
- ☐ Kidney Failure
- ☐ AIDS/ARC
- ☐ Frequent Night Urination
- ☐ MI/Heart Attack
- ☐ Current Anemia
- ☐ Cancer
- ☐ Shortness of Breath at Night
- ☐ Frequent Headaches
- ☐ Epilepsy/Seizures
- ☐ Gastric Bypass Surgery
- ☐ Chronic Cough
- ☐ Porphyria
- ☐ Artificial Joints
- ☐ Heart Valve/Pacemaker
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Ankle Swelling
- ☐ Domestic Violence
- ☐ Psychiatric Treatment
- ☐ Asthma
- ☐ Persistent Diarrhea
- ☐ Stroke
- ☐ Emphysema
- ☐ Blood Thinners
- ☐ Hepatitis A, B, or C ☐ ☐ ☐ (please check one)

Other serious illnesses or major surgeries: _____

4. For Women

Please check all the apply: ☐ Pregnant (If so, how many months?____) ☐ Nursing ☐ Taking birth control

5. Review & Consent

To the best of my knowledge the above information is correct and current.

Signature of patient/parent/guardian _____ Relationship to Patient _____ Date _____

Dentist's Signature _____ Date _____