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Health History Form

Patient Name: _____ Sex: _____
Reason for visit: _____

Are you presently under physicians' care? YES _____ NO _____
If yes, please list reason: _____
Medications (including over the counter): _____
_____
_____

Do you need <u>pre-medication</u> before dental treatment? YES _____ NO _____
If yes, please list the condition: _____

Please check any of the following that apply to you:
Bad Breath _____ Bleeding Gums _____ Jaw Pain _____ Broken Fillings _____
Loose Teeth _____ Grinding/Clenching _____ Sensitivity to Heat _____ or Cold _____

Have you ever had a reaction to or are you allergic to any of the following? (Please circle answer)

Aspirin:	YES	NO	Acrylic:	YES	NO
Codeine:	YES	NO	Metal:	YES	NO
Dental Anesthetics (Novocain):	YES	NO	Penicillin:	YES	NO
Hydrocodone	YES	NO	Other Drugs:	YES	NO
Latex:	YES	NO	If yes, please list:		

Have you ever had:

Heart Trouble:	YES	NO	Cancer:	YES	NO
High Blood Pressure:	YES	NO	Chemo/Radiation Treatment:	YES	NO
Heart Attack:	YES	NO	Tuberculosis:	YES	NO
Ulcers:	YES	NO	Epilepsy or Convulsions:	YES	NO
Rheumatic Fever:	YES	NO	Stroke:	YES	NO
Diabetes:	YES	NO	Tumor or Growth:	YES	NO
Asthma:	YES	NO	Bleeding Problems:	YES	NO
AIDS or Tested HIV Positive:	YES	NO	Herpes:	YES	NO
Kidney Disease:	YES	NO	Hepatitis or Jaundice:	YES	NO
Thyroid or Parathyroid Trouble:	YES	NO	Arthritis	YES	NO
Artificial Heart Valve	YES	NO	Artificial Joint	YES	NO
Liver Disease	YES	NO	Pacemaker	YES	NO
Sleep Apnea	YES	NO			
If YES, do you use a C-Pap	YES	NO			

Do you use Tobacco products? YES NO
If yes, how much? _____
Do you take birth control pills? YES NO
Are you pregnant? YES NO

Do you have any other conditions, diseases or problems not listed above? If yes, please describe below:
_____
_____
_____

Are you currently in Bankruptcy?: YES NO

(Over)