

Health History

Patient Name _____ Birthdate _____ Today's Date _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

- 1. _____
- 2. _____
- 3. _____

Date of last **medical** exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (please circle) Yes No

If yes, reason: _____

Please list your previous dentist: _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia	Yes	No
Heart Murmur	Yes	No
Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No
Hepatitis, Liver Disease, Jaundice	Yes	No
Rheumatic Fever	Yes	No
Asthma	Yes	No
Emphysema or other Respiratory Illness	Yes	No
Kidney Disease	Yes	No
Abnormal Heart Condition	Yes	No
Heart Surgery, Disease or Attack	Yes	No

Abnormal Blood Pressure	Yes	No
Sore/Enlarged Lymph Nodes	Yes	No
Previous Biopsies or Cancer	Yes	No
Slow-Healing Mouth Sores	Yes	No
Recurrent Illnesses	Yes	No
Joint Replacement	Yes	No
Abnormal Bleeding from a cut	Yes	No
Unintentional Weight Loss/Gain	Yes	No
HIV Infection/AIDS	Yes	No
Venereal Disease	Yes	No
Epilepsy	Yes	No

Are you required to pre-medicate prior to dental treatment? Yes No

Women: Are you Pregnant? Yes No

 If no, are you planning a pregnancy in the near future? Yes No

 Are you a nursing mother? Yes No

 Are you taking prescription birth control? Yes No

Are you allergic to or have you had a reaction to:

- a. Local anesthetic Yes No d. Codeine, Valium or other sedatives Yes No
- b. Penicillin or other antibiotics Yes No e. Latex Sensitivity Yes No
- c. Aspirin Yes No f. Other _____

Please list any medications you are currently taking:

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Are you a tobacco user? Yes No If so, how much do you use per day? _____

Is there anything of importance in your medical history that has not been asked? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient Name (Please print name)

Patient or Guardian Signature

Date

Health History Update

Name _____

Date _____ Physician's Name _____

Medications: _____

Any know Allergies: _____ Current Blood Pressure: _____

Last Medical Exam: _____ Reason: _____

Hospitalization/Surgery & Date: _____

What tobacco products, if any, do you use? _____

Signature: _____

Date _____ Physician's Name _____

Medications: _____

Any know Allergies: _____ Current Blood Pressure: _____

Last Medical Exam: _____ Reason: _____

Hospitalization/Surgery & Date: _____

What tobacco products, if any, do you use? _____

Signature: _____

Date _____ Physician's Name _____

Medications: _____

Any know Allergies: _____ Current Blood Pressure: _____

Last Medical Exam: _____ Reason: _____

Hospitalization/Surgery & Date: _____

What tobacco products, if any, do you use? _____

Signature: _____

Date _____ Physician's Name _____

Medications: _____

Any know Allergies: _____ Current Blood Pressure: _____

Last Medical Exam: _____ Reason: _____

Hospitalization/Surgery & Date: _____

What tobacco products, if any, do you use? _____

Signature: _____