PATIENT NAME: _____

Health History

Primary Physician's Name_____ Physician's Phone _____

Have you had a serious illness or operation? Y ☐ N ☐

If yes, please describe:

_____

Are you currently under physician care? Y ☐ N ☐

If yes, please describe:

_____

Please check those conditions that have ever applied to you

Conditions

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ **Artificial Heart Valve**
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ **Congenital Heart Defect**
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV+ Aids
- ☐ **Heart Attack**
- ☐ **Joint Replacement**
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ **Rheumatic Fever**
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Morphine

Other Allergies:

_____

Y N

☐ ☐ Do you Smoke or use Tobacco?

Women Only

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ **Are you pregnant? If yes, # of weeks** _____

☐ ☐ Are you nursing?

Please list any medications you are currently taking:

_____

_____

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y ( ) N ( )

Treatment Authorization: (SIGN AND DATE)

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

X_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**