Health History

Has there been any problem in your general health within the past 5 years? (illness, hospitalization, surgery) Yes ☐ No ☐
If so, what was the problem?_____
Have you ever had any form of cancer? Yes ☐ No ☐ if so what type or name? _____
Date of last medical check up _____ Attending Physician _____ Phone _____
Under a physicians care now? Yes ☐ No ☐ if so for what? _____
What pills, tablets, or liquids do you take? (includes aspirin, vitamins, tonics, etc.) _____
_____
_____
Do you require any special medication before dentistry? Yes ☐ No ☐ if so what? _____
Are you aware of any particular dental problems, discomfort or pain? _____
When was your last dental visit, and what was done at that time? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO
Rheumatic fever, rheumatic heart disease_____	☐	☐
Heart trouble, heart attack, high blood pressure___	☐	☐
Heart murmur, heart valve replacement_____	☐	☐
Pain in chest, shortness of breath, swollen ankles__	☐	☐
Blood disorder, anemia, leukemia_____	☐	☐
Cold sores or herpes infection_____	☐	☐
Positive HIV test _____	☐	☐
Asthma_____	☐	☐
Hepatitis, jaundice, liver disease_____	☐	☐
Orthopedic joint replacements _____	☐	☐
Kidney disease, dialysis, kidney infection_____	☐	☐
Do you smoke _____	☐	☐
Are you allergic to shellfish_____	☐	☐
Are you sensitive or allergic to: Penicillin_____	☐	☐
Codeine_____	☐	☐
Aspirin_____	☐	☐
Sulfa_____	☐	☐
Allergies to any other drugs, medications, or foods_	☐	☐

Please list_____
_____

	YES	NO
Tuberculosis, other lung ailments_____	☐	☐
Stroke, Fainting spells, seizures_____	☐	☐
Diabetes high or low blood sugar_____	☐	☐
Radiation treatment, for tumor or cancer_____	☐	☐
Sores that did not heal within one week _____	☐	☐
Positive test for venereal disease_____	☐	☐
Abnormal bleeding, prolonged bleeding, bruise easily	☐	☐
Low blood pressure_____	☐	☐
Arthritis, joint trouble, gout_____	☐	☐
Have you had an organ transplant_____	☐	☐
Women: Are you pregnant_____	☐	☐
Have you ever taken osteoporosis drugs?_____	☐	☐
Do you have any conditions or diseases not listed____	☐	☐

Please List:_____
_____
_____

May we ask who recommended our office to you? _____

Name:_____
Address_____
Phone: home:_____ cell: _____ work: _____ext: _____
Social Security No. _____
For what company do you work? _____ occupation: _____
Are you covered by any type of dental insurance? Yes ☐ NO ☐
If so, what insurance company? _____
If married, occupation of spouse: _____
For what company does your spouse work? _____ phone: _____
Is your spouse covered by a different dental insurance? Yes ☐ NO ☐ Insurance name: _____

Date of Birth: _____
In case of emergency, contact: Name:_____ phone: _____
Relation: _____

Patient's Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____