Health History

Patient Name: _____ Date: _____

Do you have, or have you had, any of the following conditions?

Cardiovascular Disease

- ☐ High Blood Pressure
- ☐ Arteriosclerosis
- ☐ Heart Attack If YES, then when_____
- ☐ Heart By-Pass Surgery. If YES then when_____
- ☐ Prosthetic Heart Valve
- ☐ Congenital Heart Malformations
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congestive Heart Failure (CHF)
- ☐ Other. Please explain: _____

_____

Other Medical Conditions:

- ☐ Diabetes If YES, are you taking insulin? _____
- ☐ Blood Transfusion
- ☐ Hepatitis or Liver Disease
- ☐ Stomach Ulcers
- ☐ Kidney Problems or Dialysis
- ☐ Arthritis or Rheumatism
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ HIV or AIDS
- ☐ Epilepsy
- ☐ Recurring Fainting Spells
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Cancer. If YES, are you currently on Chemo or Radiation? _____
- ☐ Joint Prosthesis (hip, knee, etc.)
- ☐ Osteoporosis
- ☐ TMJ Disorder
- ☐ Sinus Problems/Seasonal Allergies
- ☐ Asthma
- ☐ Eye Disease/Glaucoma
- ☐ Drug or Alcohol Addiction
- ☐ Psychiatric Treatment
- ☐ Antibiotic Pre-medication
- ☐ Other. Please explain: ___

_____

Allergies:

- ☐ Penicillin/Antibiotics
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Iodine
- ☐ Aspirin
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Other. Explain: ____

_____

Are you currently under a physician's care? Y N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____

Are you currently taking any medications, pills, or drugs? Y N If yes, please explain: _____

_____

For women only: Are you pregnant or trying to become pregnant Y N

Are you nursing? Y N

Are you taking care oral contraceptives? Y N

Have you had any serious illness or condition not mentioned above? Y N If yes, please explain: _____

_____

Is this dental visit related to an accident? Y N Was the accident work related? Y N Please explain: _____

_____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian_____ DATE: _____