DR. JEFF KNUTZEN
Excellence in Family & Cosmetic Dentistry

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HEALTH HISTORY

Patient Name: _____ DOB: ____/____/____

Have you ever been prescribed antibiotics **PRIOR** to dental treatment? Yes: _____ No:_____

If YES, please explain: _____

Please list any medications you are currently taking: _____

Do you currently or have you had any of the following conditions: **(Please circle Yes or No)**

Y/ N	High Blood Pressure	Y/ N	Cardiac Pacemaker	Y/ N	Angina
Y/ N	Mitral Valve Prolapse	Y/ N	Jaundice	Y/ N	Hay Fever
Y/ N	Heart Conditions/Disease	Y/ N	Epilepsy/Seizure	Y/ N	Arthritis
Y/ N	Coumadin Therapy	Y/ N	Heart Murmur	Y/ N	Fainting Spells
Y/ N	HIV/ AIDS	Y/ N	Respiratory Problems	Y/ N	Cancer
Y/ N	Kidney/Liver Disease	Y/ N	Prolonged Bleeding	Y/ N	Anemia
Y/ N	Tuberculosis/Lung Disease	Y/ N	Venereal Disease(s)	Y/ N	Asthma
Y/ N	Artificial Joints/Implants:	Y/ N	Rheumatic Fever	Y/ N	Diabetes
	Knee/Hip/Other: _____	Y/ N	Hepatitis A/B/C	Y/ N	Dizziness
Y/ N	Dementia/Alzheimer's	Y/ N	Headaches/Migraines	Y/ N	Sinus Problems
Y/ N	Nervous Disorders	Y/ N	Thyroid Disorders	Y/ N	Stroke

Are you taking any medication for Osteoporosis/Bisphosphonates? Y/ N

Do you currently smoke? Y/ N

Other: _____

Are you Allergic to any of the following? Y/ N Penicillin Y/ N Sulfa

Y/ N Codeine Y/ N Latex Y/ N Aspirin Y/ N Other: _____

Women ONLY: Are you pregnant or think you may be? Y/ N Are you nursing? Y/ N

Are you taking Birth Control Pills? Y/ N

DENTAL HISTORY

Y/ N Do you feel any pain in any of your teeth? Y/ N Do you clench or grind your teeth?

Y/ N Does dental treatment make you nervous? Y/ N Do you like your smile?

When was your last dental visit? _____ What are your dental priorities? _____

AUTHORIZATION: I have reviewed this form and assure it is accurate to the best of my knowledge. If there is any change in my medical history I will notify the dentist and staff.

Patient/Guardian Signature:_____ Date:_____

DDS Signature:_____ Comments:_____ Date: _____