Patient Name_____ DOB_____ Todays Date_____

## HEALTH HISTORY

**Please Note: Any change in your health status should be reported to this office at the earlies possible time.**

Check if you **have** or **had** any history of the following:

- € AIDS/HIV
- € Anemia
- € Anxiety/Depression
- € Arthritis/Rheumatism **Type**_____
- € Asthma
- € ADHD/ADD **please circle**
- € Autism Spectrum **Disorder** **Type**_____
- € Back Problems or Surgeries **Date of Surgeries_____**
- € Bisphosphonates Therapy **Year**_____ **If yes**, what type: Oral/IV
- € Blood Disease **Type**_____
- € Blood Transfusions **Year**_____
- € Abnormal bleeding after surgery
- € Cancer/Tumors **Type**_____
- € Chemical Dependency
- € Circulatory Problems **Type**_____
- € Congenital Heart Disease
- € Heart Surgeries
- € Cortisone Treatments
- € Diabetes/**Type** 1 or 2
- € Epilepsy
- € Excessive Bleeding
- € Eczema
- € Fainting or Dizziness
- € Glaucoma
- € Head Injuries **Type**_____
- € Headaches
- € Mummer, mitral valve, heart defect
- € Hepatitis/Type_____
- € Herpes or Cold Sores
- € High Blood Pressure
- € Low Blood Pressure
- € Jaundice
- € Jaw Pain
- € Joint Replacement Hip, Knee, shoulder
- € Kidney Disease
- € Liver Disease
- € Leukemia
- € Mitral Valve Prolapse
- € Neck Problems or Surgeries **Year**_____
- € Nervous Disorder
- € Neurological Disorder
- € Pacemaker
- € Psychiatric Care
- € Radiation Treatment
- € Respiratory Disease **Type**_____
- € Rheumatic Fever
- € Shortness of Breath
- € Sinus Trouble/Hay fever
- € Special Needs
- € Stomach Problems
- € Stroke **Year**_____
- € Swollen Neck Glands
- € Thyroid Problems
- € TMJ
- € Tobacco Habit **Type**_____
- € Tuberculosis
- € Tumors **Type**_____
- € Ulcer

**Please list any surgeries**_____Year_____

_____Year_____

_____Year_____

_____Year_____

_____Year_____

Have you ever been diagnosed with sleep apnea? **Yes or No**

Do you have any medical conditions **NOT** listed above?

_____

_____

Any recent hospitalizations? **Yes or No** If yes when and what for? _____

**Do you require a premedication/antibiotic for dental treatment? Yes or No**
**If yes Reason: _____**

## Allergies:

- € Aspirin
- € Barbiturates (sleeping pills)
- € Codeine
- € Iodine
- € Latex
- € Penicillin
- € Local Anesthetic
- € Sulfa
- € Other_____

**TO THE BEST OF MY KNOWLEDGE THE PROCEEDING QUESTIONS HAVE BEEN ACCURATELY ANSWERED.**
**Signature of Patient or Guardian_____Date_____**

## Are you taking any of the following?

- **€** Aspirin-**Dosage 81mg low dose or 325 mg Reg. dose**
- **€** Anticoagulants (blood thinners e.g. Coumadin)
- **€** Antibiotics or sulfa drugs
- **€** High blood pressure medicine
- **€** Antidepressants or tranquilizers
- **€** Insulin or other diabetes drugs
- **€** Nitroglycerin
- **€** Cortisone or other steroids
- **€** Osteoporosis (bone density) medicine
- **€** Natural Supplements **Please list them in medications**
- **€** Other:_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication?

_____

Have you ever responded adversely to medical or dental treatment?

If yes what occurred?

_____

**Please List any medications you are taking at this time**: (Including any natural supplements, eye drops, or over the counter medications)

| **Medication** | **For what Condition** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Do you Smoke, vape or use tobacco? Yes or No (If yes please circle which one you use) If yes how long___**

**Woman:**

- € Are you pregnant or plan to become pregnant?
- € Taking hormones or contraceptives

## Name of your Pharmacy

**_____Address_____**

**Phone_____**

## Name of you Primary Medical Physician:_____Phone_____

**The above information is accurate and completed to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature of Patient or Guardian_____Date_____**

**EMERGENCY CONTACT INFORMATION**

| **NAME** | **PHONE** |
|---|---|

**Signature of Doctor_____**