HEALTH HISTORY

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name____ Birth Date___________________ Age__________
Why are you now seeking dental treatment?____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	□	□
2. Are you now under the care of a physician?	□	□
If so, what is the condition being treated?____________________________		
3. Have you ever been hospitalized or had a serious illness?	□	□
If yes, explain____		
4. Have you ever had excessive bleeding following an extraction	□	□
5. Do cuts take a long time to heal?	□	□
6. (Women) Are you pregnant? If so, give due date_______________________		
7. Do you use tobacco in any form? If yes, how much_____________________		

Do you have or have you ever had any of the following? Please indicate yes or no.

GENERAL	YES	NO
Tire easily, weakness	□	□
EYES		
Glaucoma	□	□
NOSE		
Frequent nose bleeds	□	□
Sinus problems	□	□
NERVOUS SYSTEM		
Stroke	□	□
Headaches	□	□
Convulsions/epilepsy	□	□
HEART/BLOOD VESSELS		
Heart murmur	□	□
Chest pain/discomfort	□	□
Heart attack/trouble	□	□
Shortness of breath	□	□
High blood pressure	□	□
Congenital heart disease	□	□
Mitral valve prolapse	□	□
Artificial heart valve	□	□
Heart surgery	□	□
Pacemaker	□	□
Rheumatic fever	□	□
BONE/MUSCLES		
Arthritis/rheumatism	□	□
Artificial joints/limbs	□	□

DIGESTIVE SYSTEM	YES	NO
Hepatitis	□	□
Jaundice	□	□
Ulcers	□	□
URINARY		
Kidney disease	□	□
Venereal disease	□	□
BLOOD		
Bruise easily	□	□
Anemia	□	□
Blood transfusion	□	□
RESPIRATORY		
Emphysema	□	□
Asthma/hay fever	□	□
Tuberculosis	□	□
ENDOCRINE		
Diabetes	□	□
Family history of diabetes	□	□
Thyroid condition/goiter	□	□
OTHER		
Radiation therapy	□	□
Chemotherapy	□	□
Tumors or growths	□	□
Cancer	□	□
HIV+/AIDS	□	□

Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (novocaine, etc.)	□	□
Barbiturates/sedative/sleeping pills	□	□
Penicillin/other antibiotics	□	□
Aspirin or codeine	□	□
Sulfa drugs	□	□
Other allergies___________________________		

Does dental treatment make you nervous? No______ Slightly_______ Moderately _______ Extremely _______
If so, would you be interested in sedation dentistry? __________________________

(please turn the paper over and answer remaining questions)

Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs……………	□	□
Blood thinners…………………….	□	□
Blood pressure medication ………..	□	□
Thyroid medication……………….	□	□
Cortisone/steroids………………….	□	□
Antihistamines/allergy drugs/ Cold remedies…………………	□	□

	YES	NO
Birth control pills………………….	□	□
Insulin/other diabetes drugs……….	□	□
Recreational drugs…………………	□	□
Heart medications………………….	□	□
Nitroglycerin……………………….	□	□
Aspirin……………………………..	□	□
Other medication…………………..	□	□

If yes to any of the above, please list **name** of medication and **dosage** in space below:

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Is there any disease, condition or problem not listed above that you think we should know about? If yes, please explain:

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Have you ever had treatment for breast cancer or have you been treated with chemotherapeutic drugs and intravenous Bisphosphonates? □ **YES** □ **NO** (Intravenous Bisphosphonate therapy, or bone-sparing drugs are commonly used in the treatment of osteoporosis and metastatic bone cancer to help decrease associated pain and fractures following treatment for breast cancer.)

Physician's Name____ Phone Number_______________

Have you ever had any serious trouble associated with previous dental treatment? _________________________

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To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian_______________________________________ Date_________________