HEALTH HISTORY

Patient Name:_____ Birthdate:____/____/_____
Last First Middle Mo Day Year

Name of Medical Doctor: _____ City/State: _____

PLEASE SELECT 'YES OR NO' TO ALL QUESTIONS. IF NO, THEN YOU STILL MUST CHECK NO.

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

YES	NO		YES	NO		YES	NO	
( )	( )	Asthma	( )	( )	High Blood Pressure	( )	( )	Rheumatic Fever
( )	( )	Bleeding Problems	( )	( )	HIV/AIDS	( )	( )	Seizure's
( )	( )	Cancer	( )	( )	Joint Replacement	( )	( )	Sinus Trouble
( )	( )	Diabetes	( )	( )	Kidney Disease	( )	( )	Stroke
( )	( )	Hepatitis	( )	( )	Liver Disease (including Hepatitis)	( )	( )	Thyroid Disease
( )	( )	Herpes	( )	( )	Pacemaker	( )	( )	Tuberculosis
( )	( )	Heart Trouble (attack, murmur, stent, valve, etc.)	( )	( )	Pregnant/Nursing	( )	( )	Ulcers
			( )	( )	Psychiatric Treatment			

Any other medical conditions not listed here? _____

Are you allergic to any of the following?

YES	NO		YES	NO	
( )	( )	Anesthetic (Local)	( )	( )	Iodine
( )	( )	Aspirin	( )	( )	Latex
( )	( )	Barbiturates	( )	( )	Metals
( )	( )	Bee's	( )	( )	Peanuts/Treenuts
( )	( )	Codeine	( )	( )	Penicillin
( )	( )	Ibuprofen	( )	( )	Sulfa Drugs

Any other allergies not listed here? _____

List all medications you are taking, including over the counter:

( ) Check if you are required to **pre-med with antibiotics**.

_____
_____
_____
_____
_____
_____

Do you take a daily baby aspirin? YES NO

Have you ever taken Bisphosphonate medication (Fosamax, Prolia, etc.) YES NO
Are you under medical treatment now? (Y) (N) **Explain:**_____
Have you been hospitalized? (Y) (N) **Explain:**_____
Tobacco use? (Y) (N) **Select:** (Smoke) (Chew) (Both)
Do you have any dental problems? (Y) (N) **Explain:**_____
Do you have dental anxiety? (Y) (N) **Explain:**_____
Are you happy with your smile? (Y) (N) **Explain:**_____
Would you like whiter teeth? (Y) (N)

Name of former dentist: _____ City/State:_____ Date of Last Visit:___/___/___

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health.

_____ _____/_____/_____
Signature of Patient, Parent, or Guardian **Date**

_____
Reviewing Dentist

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