Health Information

Patient Name: ____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/ HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Breathing Problems
☐ Cancer
☐ Diabetes
☐ Epilepsy/ Seizures
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/ MVP
☐ Hepatitis A B C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems/ Ulcers
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Thyroid Disease
☐ Venereal Disease
☐ Alcoholism
☐ Drug Addiction
OTHER:
☐ ________________
☐ ________________

- Are you taking any prescription medication, over-the counter, vitamins, or herbals? If yes, please list:

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- Are you allergic to any medication or substances? If yes, please list:

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Aspirin_______ Penicillin________ Codeine________ Acrylic________ Metal________ Latex________ Other_________

- Have you ever or are you now being treated with?
  Radiation_______ Chemotherapy______ Reclast______ Zometa I.V._______ Fosamax/Actonel/Boniva_______
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ____ Phone: ____________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you ever been told by a doctor that you need to pre-medicate before dental procedures/ cleanings? ______________

Dental History

Do you have any specific dental problem? Describe:_____________________________________ ☐ Yes ☐ No

Do you think you have gum disease?____ ☐ Yes ☐ No

Do you have sensitive gums or do your gums bleed? ______________________________________ ☐ Yes ☐ No

Does food ever get caught in between your teeth?____ ☐ Yes ☐ No

Do you grind or clench your teeth? ____ ☐ Yes ☐ No

Do you smoke or chew tobacco? ____ ☐ Yes ☐ No

I have answered to the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: _______________________

Signature of patient, parent or guardian

Reviewed by Doctor: ____Date:__________________________

Comments:

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