Health History

Your name_____Today's date_____
Physician name and phone _____Date of last visit_____

Are you in good health? ❑ Yes ❑ No
Are you willing to make an effort to keep your teeth? ❑ Yes ❑ No
Have you been hospitalized in the last 5 years? ❑ Yes ❑ No
Have you ever responded adversely to any medical/dental treatment or anesthetic? ❑ Yes ❑ No
Have you ever premedicated with antibiotics before a dental appointment? ❑ Yes ❑ No

For Women: Are you Pregnant? ❑ Yes ❑ No Are you Nursing? ❑ Yes ❑ No

List all medications or supplements that you are taking: _____ _____ _____ _____ _____ _____ _____ _____

Are you taking aspirin daily? ❑ Yes ❑ No How many mg? _____

List all medications that you are allergic to: _____

Check if you ever ❑ Smoke ❑ Vape If yes, how much per day? _____ Year Quit? _____

Check any of the following that you have had or are currently being treated for:

❑ Alcohol Use
❑ Allergies
❑ Anemia
❑ Arthritis/Gout
❑ Artificial Heart Valve
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Bleeding Problems
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Diabetes
❑ Diet Pills (fen-phen)
❑ Dry Mouth
❑ Epilepsy or Seizures
❑ Fainting or Dizziness
❑ Glaucoma
❑ Heart Attack
❑ Heart Murmur
❑ Heart Problems
❑ Heart Surgery
❑ Hepatitis Type_____
❑ High Blood Pressure
❑ HIV/AIDS
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Liver Problems
❑ Low Blood Pressure
❑ Lung Problems
❑ Mitral Valve Prolapse
❑ Nervous/Anxious
❑ Osteoporosis
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Therapy
❑ Shortness of Breath
❑ Sinus Problems
❑ Steroid Treatment
❑ Stomach Problems
❑ Stroke
❑ Swelling of Ankles
❑ Thyroid Problems
❑ Ulcer
❑ Weight Loss
❑ Other _____

Check any of the following that you have had or having problems with:

❑ Bleeding Gums
❑ Deep Scalings
❑ Dental Pain
❑ Grinding/Clenching Teeth
❑ Gum Surgery
❑ Sensitivity to Hot/Cold
❑ Sensitivity when Biting
❑ Sores/Lumps in Mouth
❑ Tender Jaw Joint
❑ Other _____

Is there anything else we should know about your medical or dental history? _____
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