HEALTH HISTORY FORM

Patient Name: ______________________________ Date of Birth: ______________

Physician's name, phone, and date of last exam: ______________________________

Yes **No** Do you take medications? If so, please list: ______________________________

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Yes **No** Do you have allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: ______________________________

Yes **No** Have you been hospitalized? If so, please list dates and reasons: ______________________________

Do you have or have you ever had any of the following (if "Yes", please circle which):

Yes **No** Artificial joints (hip, knee, etc.)
Yes **No** High blood pressure / Angina / Arrhythmias
Yes **No** Heart disease / Heart attack / Defibrillator
Yes **No** Artificial heart valve / Pacemaker
Yes **No** Bleeding disorders / Prolonged bleeding
Yes **No** Anemia / Leukemia / Blood dyscrasias
Yes **No** Stroke / Aneurysm
Yes **No** Seizures
Yes **No** Hepatitis / Liver disease / Kidney problems
Yes **No** HIV / AIDS
Yes **No** Ulcers / Stomach problems
Yes **No** Osteoporosis / Bone disease
Yes **No** Diabetes / Family History of Diabetes
Yes **No** Thyroid / Adrenal problems

Yes **No** Periodontal (gum) disease
Yes **No** Family history of periodontal disease
Yes **No** Cancer / Tumors
Yes **No** Chemotherapy / Radiation treatment
Yes **No** Sinus problems / Ear problems
Yes **No** Asthma / Tuberculosis / Lung disease
Yes **No** Arthritis / Lupus
Yes **No** Anxiety / Depression / Psychiatric treatment
Yes **No** Dental anxiety
Yes **No** Sleep Apnea
Yes **No** TMJ Pain / Disorder
Yes **No** Tobacco use
Yes **No** Drug / Alcohol abuse
Yes **No** Currently Pregnant / Nursing

Yes **No** Any other medical problems? If so, please describe: ______________________________

Yes **No** Do you prefer some form of sedation for dental procedures? If "Yes", please circle which

Nitrous oxide (laughing gas) Oral sedation IV sedation

Yes **No** Is there anything you would like to change about your smile/teeth? ______________________________

How often do you: brush your teeth______________ floss your teeth____________

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: ______________________________ Date: ______________

Hygienist/Assistant Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________

Revised: June 5, 2018