HEALTH HISTORY

Patient's Name____ Date of Birth____________________

ALLERGIES:

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Barbiturates
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Latex
- ☐ Metals
- ☐ Other: ________________________

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MEDICATIONS:

Please list medications you are currently taking:

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Check (☐) if you have had any of the following:

☐ Alcoholism	☐ Diabetes: TYPE I TYPE II	☐ Heart Murmur*	☐ Low Blood Pressure
☐ Anemia	☐ Eating Disorder	☐ Heart Stents*	☐ Mitral Valve Prolapse*
☐ Angina Pectoris	☐ Emphysema	☐ Heart Shunt*	☐ Persistent cough
☐ Arthritis	☐ Epilepsy or seizures	☐ Hepatitis A	☐ Rheumatic Fever*
☐ Artificial Joints*	☐ Fainting or dizzy spells	☐ Hepatitis B	☐ Seasonal Allergies
☐ Asthma	☐ Glaucoma	☐ Hepatitis C	☐ Sinus Trouble
☐ Back Problems	☐ Headaches	☐ High Blood Pressure	☐ Steroid Treatment*
☐ Birth Defects	☐ Heart Problems	☐ History of drug addition	☐ Stroke
☐ Bruise Easily	☐ Heart Failure	☐ HIV Positive, AIDS	☐ Tobacco habit
☐ Cold Sores	☐ Heart Disease	☐ Kidney trouble	☐ Tuberculosis
☐ Denture or Partials	☐ Heart Pacemaker*	☐ Liver Disease	☐ Ulcers

***Antibiotic pre-medication may be required prior to your appointment.**

Has a physician recommended that you take antibiotic pre-medication prior to dental treatment? Yes No

Check (☐) if you have had any problems with the following:

- ☐ Bad Breath
- ☐ Bleeding/tender gums
- ☐ Periodontal treatment history
- ☐ History of trauma to your jaw
- ☐ Clicking, popping or jaw pain
- ☐ Difficulty opening/closing jaw
- ☐ Difficulty chewing
- ☐ Wear a splint or night guard
- ☐ Have been diagnosed with TMJ/TMD
- ☐ Sensitivity to cold, hot, sweets or pressure
- ☐ Sores, lumps, or growths in mouth or lips
- ☐ Difficultly with extractions in the past
- ☐ Prolonged bleeding following extractions
- ☐ Taken diet drugs Redux, Pondimin, or Phen-Fen

Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? Yes No

If yes, when was the operation done? ____

Have you ever suffered a Heart Attack? Yes No If yes, date of last heart attack: ________________

Do you have/had Cancer? Yes No Type: __________________ Are you undergoing treatment? Yes No

Is there anything related to your medical/dental history that you have not indicated above? Yes No

If yes, please explain:____

WOMEN: Are you pregnant now? Yes No If yes, when is your due date?________________

Are you currently breast feeding? Yes No Are you taking oral contraceptives? Yes No