Date_____

HEALTH HISTORY FORM

Name_____
Last **First** **M. I.**

Date of Birth____/____/____ **Sex: M F** **Height**_____ **Weight**_____

Your Physician_____ **City**_____ **Phone**_____

Previous Dentist_____ **City**_____ **Phone**_____

Emergency Contact_____**Relationship**_____

Home Phone_____ **Cell Phone** _____**City**_____

Note: Your answers are for our records only and will be considered confidential.

Yes No Date of last physical examination:_____

		Are you in good health?
		Are you currently under the care of a physician?
		Any changes in your general health in the last year?
		If yes, please explain:
		Have you had any serious illness, operation or hospitalized within the last five years?
		If yes, please explain:

Please list any prescription and non-prescription medications you are taking

Medication	**Reason**

Please check if applies to you

	Allergy, Hay Fever		**Hepatitis, jaundice or liver disease**
	Arthritis or Swollen Joints		**HIV infection or AIDS**
	Artificial Heart Valve		**Immune System Problems**
	Blood Disorders		**Kidney Disorders**
	Blood Pressure Problems		**Mental Health Problems**
	Blood Transfusion		**Prosthetic Joints**
	Cancer		**Respiratory Problems (asthma, emphysema, TB, etc)**
	Cardiovascular Problems		**Sinus Problems**
	Diabetes		**Stomach Ulcers or Hyperacidity**
	Epilepsy or other neurological disease		**Thyroid Problems**
	Fainting spells or seizures		**Other**

Please check if you are allergic to or have had a reaction to

	Local Anesthetics		**Codeine**
	Aspirin		**Penicillin or other antibiotics**
	Barbiturates or sedatives		**Other**

OVER

When was your last dental cleaning? _____

Yes	No	
		Have you had any serious trouble associated with any previous dental treatment?
		If yes, please explain:
		Do your gums bleed when brushing or flossing?
		Do you clench or grind your teeth when awake or asleep?
		Do you smoke? If yes, how much:

Women

Yes	No	
		Are you pregnant?
		Are you nursing?
		Do you take oral contraceptives?

Chief Dental Complaint:_____

I certify that I have read and understand the above.
I acknowledge that my answers to the questions
above have been completed to my satisfaction.

_____
Signature of Patient or parent/guardian of minor patient

To be completed by Dentist

Comments on patient interview concerning medical history:_____
_____
_____
_____
_____
_____
_____

Dental Management Considerations:_____
_____
_____

_____ **_____**
Date **Signature of Dentist**

Medical History Update

Date	Comments	Signature of Dentist