HEALTH HISTORY

Patient Name:_____ Birthdate:____/____/_____
Last First Middle Mo Day Year

Name of Medical Doctor: _____ City/State: _____

PLEASE SELECT 'YES OR NO' TO ALL QUESTIONS. IF NO, THEN YOU STILL MUST CHECK NO.

Do you have, or have had any of the following medical conditions?

YES	NO		YES	NO	
( )	( )	Asthma	( )	( )	Kidney Disease
( )	( )	Bleeding Problems	( )	( )	Liver Disease
( )	( )	Cancer	( )	( )	Pregnancy (check Yes if currently pregnant)
( )	( )	Diabetes	( )	( )	Psychiatric Treatment
( )	( )	Heart Murmur	( )	( )	Rheumatic Fever
( )	( )	Heart Trouble	( )	( )	Sinus Trouble
( )	( )	High Blood Pressure	( )	( )	Stroke
( )	( )	Joint Replacement	( )	( )	Ulcers

Any other medical conditions not listed here? _____
_____

Are allergic to any of the following?

YES	NO		YES	NO	
( )	( )	Anesthetic (Local)	( )	( )	Iodine
( )	( )	Aspirin	( )	( )	Latex
( )	( )	Barbiturates	( )	( )	Metals
( )	( )	Codeine	( )	( )	Penicillin
( )	( )	Ibuprofen	( )	( )	Sulfa Drugs

Any other allergies not listed here? _____
_____

List all medications you are taking:

( ) Check if you are attaching separate medication list.

_____
_____
_____
_____
_____
_____
_____

	YES	NO	
Are you under medical treatment now?	( )	( )	**Explain:**_____
Have you been hospitalized?	( )	( )	**Explain:**_____
Tobacco use?	( )	( )	**Select:** (Smoke) (Chew) (Both)
Do you have any dental problems?	( )	( )	**Explain:**_____
Do you have dental anxiety?	( )	( )	**Explain:**_____
Are you happy with your smile?	( )	( )	**Explain:**_____
Would you like whiter teeth?	( )	( )	

Name of former dentist: _____ City/State:_____ Date of Last Visit:___/___/___

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____/_____/_____
Signature of Patient, Parent, or Guardian **Date**

_____
Reviewing Dentist

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