Date _____

HEALTH HISTORY

Patient name: _____ Date of Birth _____

Physician's name: _____

Have you ever been hospitalized or had a major operation? YES NO If yes, explain: _____
Have you ever had a serious head or neck injury? YES NO _____
Do you take, or have taken, Fen-phen or Redux? YES NO _____
Do you use tobacco? YES NO _____
Do you snore? YES NO _____

Place a mark on "yes " of "no" to indicate if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			**Cortisone Treatments**			**Hemophilia**			**Renal Dialysis**		
Alzheimer's Disease			**Diabetes**			**Hepatitis A**			**Rheumatic Fever**		
Anaphylaxis			**Drug Addiction**			**Hepatitis B or C**			**Rheumatism**		
Anemia			**Easily Winded**			**Herpes**			**Scarlet Fever**		
Angina			**Emphysema**			**High Blood Pressure**			**Shingles**		
Arthritis/Gout			**Epilepsy or Seizures**			**Hives or Rash**			**Sickle Cell Disease**		
Artificial Heart Valve			**Excessive Bleeding**			**Hypoglycemia**			**Sinus Trouble**		
Artificial Joint			**Excessive Thirst**			**Irregular Heartbeat**			**Spina Bifida**		
Asthma			**Fainting Spells/Dizziness**			**Kidney Problems**			**Stomach/Intestinal Disease**		
Blood Disease			**Frequent Cough**			**Leukemia**			**Stroke**		
Blood Transfusion			**Frequent Diarrhea**			**Liver Disease**			**Swelling of Limbs**		
Breathing Problem			**Frequent Headaches**			**Low Blood Pressure**			**Thyroid Disease**		
Bruise Easily			**Genital Herpes**			**Lung Disease**			**Tonsillitis**		
Cancer			**Glaucoma**			**Mitral Valve Prolapse**			**Tuberculosis**		
Chemotherapy			**Hay Fever**			**Pain in Jaw Joints**			**Tumors of Growths**		
Chest Pains			**Heart Attack/Failure**			**Parathyroid Disease**			**Ulcers**		
Cold Sores/Fever Blisters			**Heart Murmur**			**Psychiatric Care**			**Venereal Disease**		
Congenital Heart Disorder			**Heart Pace Maker**			**Radiation Treatments**			**Yellow Jaundice**		
Convulsions			**Heart Trouble/Disease**			**Recent Weight Loss**			**Women: Pregnant**		

MEDICATIONS	**ALLERGIES**
List all your medications: _____ _____ _____ _____ _____ _____ _____	Aspirin ___ Codeine ___ Iodine ___ Latex ___ Local Anesthetic ___ Penicillin ___ Sulfa ___ Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

MEDICAL HISTORY UPDATES (to be filled in future appointments) **Date** _____

Patient name: _____ Date of Birth _____

Has there been any change in your health and/or medical history since your last dental appointment? ___Yes ___No
If yes, please explain: _____

_____

_____

_____

_____

Are you taking any new medications? Be sure to include any nonprescription medicines you are taking. ___Yes ___ No

If yes, please list all medications:_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

NAME OF PARENT or GUARDIAN_____

MEDICAL HISTORY UPDATES (to be filled in future appointments) **Date** _____

Patient name: _____ Date of Birth _____

Has there been any change in your health and/or medical history since your last dental appointment? ___Yes ___No
If yes, please explain: _____

_____

_____

_____

_____

Are you taking any new medications? Be sure to include any nonprescription medicines you are taking. ___Yes ___ No

If yes, please list all medications:_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

NAME OF PARENT or GUARDIAN _____