Patient Name _____ Date _____

Health History

Medical Doctor's Name _____
Clinic Name and Phone# _____
Pharmacy Name _____
Phone # _____

Place a mark on yes or no to indicate if you have the following:

AIDS/HIV	_Yes	_No
Anemia	_Yes	_No
Arthritis, Rheumatism	_Yes	_No
Artificial Heart Valve	_Yes	_No
Artificial Joint	_Yes	_No
date_____		
Asthma	_Yes	_No
Back Problems	_Yes	_No
Bleeding abnormally,		
with extractions	_Yes	_No
Blood Disease	_Yes	_No
Blood Thinners	_Yes	_No
Bone Builders		
ex: Fosamax	_Yes	_No
Cancer	_Yes	_No
Chemical Dependency	_Yes	_No
Chemotherapy	_Yes	_No
Circulatory Problems	_Yes	_No
Diabetes, type _____	_Yes	_No
Emphysema	_Yes	_No
Epilepsy/Seizures	_Yes	_No
Fainting or dizziness	_Yes	_No
Glaucoma	_Yes	_No
Headaches	_Yes	_No
Heart Murmur	_Yes	_No
Females: pregnant	_Yes	_No
birth control pill	_Yes	_No

Heart Problems	_Yes	_No
Hepatitis, type_____	_Yes	_No
Herpes		
cold sores	_Yes	_No
canker sores	_Yes	_No
High Blood Pressure	_Yes	_No
Jaw Pain / TMJ/TMD	_Yes	_No
Kidney Disease	_Yes	_No
Liver Disease	_Yes	_No
Mitral Valve Prolapse	_Yes	_No
Pacemaker	_Yes	_No
Psychiatric care	_Yes	_No
Radiation treatment	_Yes	_No
Respiratory Disease	_Yes	_No
Rheumatic Fever	_Yes	_No
Shortness of Breath	_Yes	_No
Sinus Trouble	_Yes	_No
Stroke	_Yes	_No
Swollen feet or ankles	_Yes	_No
Swollen neck glands	_Yes	_No
Thyroid Problems	_Yes	_No
Tonsillitis	_Yes	_No
Tuberculosis	_Yes	_No
Venereal Disease	_Yes	_No
Tobacco Usage		
smoking	_Yes	_No
chewing	_Yes	_No

MEDICATIONS

List any medicines you are taking:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES

_ Aspirin
_ Codeine
_ Latex
_ Metals
_ Other:

_ Penicillin
_ Sulfa
_ Local Anesthetic (Novocaine, Etc.)

_____
_____
_____