Health History

Patient Name:_____ Date of Birth_____

Pharmacy & Number _____

Please mark "yes" or "no" if you have or had any of the following:

	Yes	No			Yes	No	
AIDS/HIV	__	__		Artificial heart valves	__	__	
Anemia	__	__		Artificial joints	__	__	
Arthritis	__	__		Back Problems	__	__	
Asthma	__	__		Bleeding Disorders	__	__	
Cancer	__	__		Fainting/Dizziness	__	__	
Chemotherapy	__	__		Heart Problems	__	__	Type _____
Diabetes	__	__		High Blood Pressure	__	__	
Epilepsy	__	__		Kidney Disease	__	__	
Glaucoma	__	__		Liver Disease	__	__	
Headaches	__	__		Mitral Valve Prolapse	__	__	
Hepatitis	__	__	Type ___	Pacemaker	__	__	
Skin Rash	__	__		Sinus Trouble	__	__	
Stroke	__	__		Radiation Treatment	__	__	
Tuberculosis	__	__		Thyroid Problems	__	__	
Tumors	__	__		Swollen Feet	__	__	
Ulcers	__	__		Shortness of Breath	__	__	

Have you had any surgeries or conditions not listed? Please list.

_____

_____

Are you taking bisphosphonates for osteoporosis? Yes ___ No ___
Do you require antibiotics before every dental procedure? Yes ___ No ___
Are you anxious about dental appointments? Yes ___ No ___
Do local anesthetics routinely make your heart rate increase? Yes __ No __

Women: Are you pregnant? ___ Are you nursing? ___ Taking birth control pills? ___

Medications: Please list any medications you are currently taking.

_____

_____

_____

Allergies: Please check any allergies. No allergies __

Aspirin __ Codeine __ Iodine __ Latex __ Sulfa __
Antibiotics: please list. _____
Other: _____

Patient Signature: _____ Date: _____