Health History

Patient Name: _____ Date of Birth: _____

Emergency Contact and number: _____

Pharmacy & Number: _____

Please circle Yes or No for the following conditions:

AIDS/HIV	Y	N		High Blood Pressure	Y	N
Arthritis	Y	N		Kidney Disease	Y	N
Asthma	Y	N		Liver Disease	Y	N
Artificial Joint	Y	N	Year_____	Skin Rash	Y	N
Anemia	Y	N		Smoker	Y	N
Back Problem	Y	N		Sinus Infections	Y	N
Diabetes	Y	N	Type_____	Tuberculosis	Y	N
Epilepsy	Y	N		Ulcers/GERD	Y	N
Glaucoma	Y	N		Thyroid Problems	Y	N
Headaches	Y	N	Type_____	Swollen Feet	Y	N
Hepatitis	Y	N	Type_____	Shortness of Breath	Y	N

Please list current medications (Please use back of sheet if more space needed):

_____

_____

Please list surgeries or conditions not listed (Please use back of sheet if more spaced needed):

_____

Please Indicate NA if condition does not apply

Stroke: Date: _____

Heart Conditions: Heart Attack: Date: _____ Stents/valves: _____

Pace Maker: _____ Reason Placed: _____

Year Placed: _____ How frequently does it activate? _____

Last activation date: _____

Cancer: Type: _____ Surgery/date: _____

Chemotherapy/Radiation: _____ Last Treatment: _____

Fainting/Dizziness: Cause: _____ Frequency: _____

Last episode date: _____

Bleeding Disorders: Type and Medications: _____

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Women: Are you Pregnant: Y N Are You Nursing? Y N Birth Control Pills: Y N

Are you taking bisphosphonates for Osteoporosis? Y N

Are you on a prescription blood thinner? Y N

Do local anesthetics routinely make your heart race? Y N

Are you required to pre-medicate with antibiotics for a medical condition before Dental Procedures? Y N

When was the last time you took an antibiotic for this tooth? Date: _____

Antibiotic and dose: _____

Allergies: Please circle all that apply

No Known Drug Allergies

Aspirin Codeine Iodine Sulfa Penicillin/Amoxicillin Latex

Other Drug allergies: _____

Other allergies: _____

Patient Signature: _____ Date: _____

For Office use only: ASA Classification: _____ Blood Pressure: _____

Dr. Initial _____