HEALTH HISTORY

Patient Name____Birthdate_____________

Many medical situations can affect or be affected by dental procedures. Please complete the questionnaire carefully. Your records will be kept confidential.

What prompted you to seek dental care at this time? ______________________________
When was your last dental examination? ____

PLEASE CIRCLE

YES NO Are you worried about receiving dental treatment?
YES NO Have you ever had any previous bad dental experiences?
YES NO Do your gums bleed when brushing or flossing your teeth?
YES NO Are you currently under medical treatment?
If yes, please explain____
YES NO Are you taking prescription drugs or medicine?
If yes, please list____
YES NO Do you have medical conditions which would require pre-medication for dental treatment? If yes, please explain_____________________________
YES NO Are you allergic to any drugs of medicine? (Penicillin, Antibiotics, Codeine, Aspirin, and Novocain) if yes, please list___________________
YES NO Any other allergies? If yes, please list______________________________
YES NO Have you ever had any excessive bleeding requiring special treatment?
If yes, please explain____
____
YES NO Are you currently pregnant?
YES NO Are you taking Birth Control Pills?

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

Heart Trouble	Heart Murmur	Congenital Heart Disease	Anemia
Hepatitis	Arthritis	High Blood Pressure	Rheumatic Fever
HIV, AIDS	Jaundice	Stroke	
Psychiatric Treatment	Epilepsy	Asthma	Kidney Disease
Artificial Joints	Diabetes	Sinus Trouble	Hospitalization
Artificial Valves	Tuberculosis	Radiation Treatment	Congenital Heart Disease
Implants	Operations	Blood Transfusion	

Mitral Valve Prolapse Cancer or Tumor Breathing Problems
Excessive Weight Gain or Loss Pacemaker

PLEASE EXPLAIN BELOW OTHER HEALTH CONDITIONS WE SHOULD KNOW:

The information given above is accurate to the best of my knowledge.

Patient (or Guardian) Signature ________________________________Date_______