# Health History

Patient Name: _____ Date of Birth: _____/_____/_____ Weight: _____

1. Mark all of the following for which you have or have had:

___ High Blood Pressure
___ Heart Murmur
___ Prolapsed Mitral Valve
___ Artificial Heart Valve
___ Heart Attack
___ Heart Surgery
___ Congenital Heart Disease
___ Congenital Heart Defect
___ Infective Endocarditis
___ Pacemaker
___ Angina
___ Artificial Joint(s)
Date Joint(s) placed: _____
___ Cancer
Type of cancer and status: _____

___ Stroke
___ Diabetes
___ Kidney Disease
___ Liver Disease
___ Hepatitis A,B,or C
___ Tuberculosis
___ Alzheimer's Disease
___ Hemophilia
___ Psychiatric Treatment
___ Depression
___ Rheumatic Fever

___ Thyroid Disorder
___ Epilepsy
___ Asthma
___ Asthma Inhaler
___ HIV
___ AIDS
___ Drug Addiction
___ Currently Nursing
___ Currently Pregnant
___ Jaw Joint Popping
___ Jaw Joint Pain

List Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

2. Have you had any serious condition, disease, or illness not listed above? If yes, what? _____

_____

3. Name, City, and Phone number of your personal physician: _____

4. Are you allergic to penicillin? _____ Are you allergic to any other drugs or anything else? _____

_____

5. What concerns do you have about your dental health? _____

6. Are you happy with the appearance of your smile?_____ If not, why? _____

_____

7. Have you had any problems with any previous dental care? _____ If yes, what? _____

_____

8. Do you smoke? _____ Do you use smokeless tobacco? _____

9. When was your last dental exam? _____ Is it important for you to keep your teeth? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner and I have answered all questions truthfully and fully. If further information is needed from another health care provider, you have my permission to contact them and request release of all necessary information. I will notify you of any changes in my health or medication.

**X** _____ _____/_____/_____
Signature of patient or parent/guardian if patient is a minor Date

My initials indicate I have reviewed the information above and made any necessary changes.

_____ _____ _____ _____ _____ _____
Date and Initials

_____ _____ _____ _____ _____ _____