Health History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First Name - Patient

Middle Name

Last Name - Patient

Medical Information

- [ ] Are you taking any prescription or over-the-counter medicines?

Allergies

- [ ] Acetaminophen/Tylenol®
- [ ] Acrylic
- [ ] Amoxicillin
- [ ] Aspirin
- [ ] Codeine
- [ ] Epinephreine
- [ ] Erythromycin
- [ ] Fluoride
- [ ] Hay fever/seasonal
- [ ] Ibuprofen/Motrin®/Advil®
- [ ] Iodine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Metals
- [ ] Nickel
- [ ] Penicillin
- [ ] Sulfa
- [ ] Tetracycline
- [ ] Other

Please elaborate on any reactions you have to the indicated allergies

Conditions

- [ ] Abnormal/excessive bleeding
- [ ] AIDS or HIV infection
- [ ] Alzheimer's/dementia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood disease
- [ ] Blood transfusion
- [ ] Breathing problems/respiratory disease
- [ ] Bronchitis
- [ ] Cancer/chemotherapy/radiation treatment
- [ ] Cardiovascular disease
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing difficulties
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart rhythm disorder
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] Kidney problems
- [ ] Low blood pressure
- [ ] Low pain tolerance
- [ ] Malnutrition
- [ ] Mitral valve prolapse
- [ ] Neurological disorders
- [ ] Night sweats
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Persistent swollen glands in neck
- [ ] Psychiatric care
- [ ] Recurrent Infections
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted infection (STI)
- [ ] Sinus trouble
- [ ] Stroke
- [ ] Systemic lupus erythematosus
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers

- [ ] Other

Do you have any disease, condition or problem that is not listed that you think I should know about?

- [ ] Have you ever reacted adversely to any medications or injections?
- [ ] Do you have sleep apnea?
- [ ] Do you have severe issues with coughing?
- [ ] Have you ever taken FosaMax®, Boniva®, Actonel®, or other medications containing bisphosphonates?
- [ ] Do you drink alcoholic beverages?
- [ ] Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- [ ] Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
- [ ] Has there been any change to your general health within the past year?
- [ ] Do you use tobacco (smoking, snuff, chew, bidis, vaping)?
- [ ] Are you wearing a nicotine patch?

- [ ] Have you had a serious illness, operation, or been hospi talized in the past 5 years?

Please list any surgical procedures you have undergone and when they occ urred.

For women only:

- [ ] Are you pregnant?
- [ ] Are you taking birth control or hormone replacement?
- [ ] Are you nursing?

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Print name

I agree that the information provided in this form is correct to the best of my knowledge.

Clear