

Health History

Physician's Name _____ Date of last visit _____
 Place circle "Yes" or "No" to indicate if you have had any of the following:

AIDS	Yes	No	Epilepsy	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Radiation Treatment	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Respiratory Disease	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Shortness of Breath	Yes	No
Back Problems	Yes	No	Hepatitis (Type _____)	Yes	No	Sinus Trouble	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	Herpes	Yes	No	Skin Rash	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No			
Cancer	Yes	No	HIV Positive	Yes	No	Special Diet	Yes	No
Chemical Dependency	Yes	No	Jaundice	Yes	No	Stroke	Yes	No
Chemotherapy	Yes	No	Jaw Pain	Yes	No	Swelling of Feet or Ankles	Yes	No
Circulatory Problems	Yes	No	Kidney Disease	Yes	No	Swollen Neck Glands	Yes	No
Congenital Heart Lesions	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Cortisone Treatments	Yes	No	Low Blood Pressure	Yes	No	Tonsillitis	Yes	No
Cough, persistent or bloody	Yes	No	Mitral Valve Problems	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Nervous Problems	Yes	No	Tumor or growth on head or neck	Yes	No
Emphysema	Yes	No	Pacemaker	Yes	No	Ulcer	Yes	No
Do you wear contact lenses?	Yes	No	Women:			Venereal Disease	Yes	No
Weight Loss, unexplained	Yes	No	Are you pregnant?	Yes	No			
			Are you Nursing?	Yes	No			

Medications

List medications you are currently taking:

Pharmacy Name _____

Phone _____

Allergies (please circle)

Aspirin _____ Local Anesthetic _____

Barbiturates _____ Penicillin _____

Codeine _____ Sulfa _____

Iodine _____ Other _____

Latex _____

Updates

(To be filled in at future appointments)

Have there been any changes in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Have there been any changes in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____