HEALTH INFORMATION AND HISTORY

Patient's Name_____ Medical Doctor's Name_____City_____State_____
Date of Last Physical Exam_____ Date of Last Blood Test or Blood Work-Up_____ Zip_____

	YES	NO
Are You Presently Taking Any Medications, Drugs, Pills, Over-the-Counter Medications, or Having Medical Treatments? If Yes, Please list	___	___
_____	___	
Are You Allergic to or Every Had Any Reaction to Any of the Following:		
Penicillin ____ Codeine____ Latex____		
Erythromycin____ Aspirin_____ Fluoride____		
Tetracycline ____ Ibuprofen (Advil, Motrin, Nuprin)____		
Are You Allergic to or Every Had Any Reaction to Any Other Medications, Drugs, Pills or Treatments?	___	___
If Yes, Please List_____		
_____		
Do You Have Asthma, Hay fever, or Allergies in General	___	___
Have You Ever Been Instructed to Take Any Special Precautions Or Pre-medications before any Dental Appointments?	___	___
If Yes, Please Explain What Medications and Why		
_____		
_____		
Do You Have Any Heart Ailments or Problems?	___	___
Have You Ever Had Any Type of Heart Surgery Or Other Cardiac Procedure?	___	___
Do You Have Any Congenital Heart Lesions?	___	___
Have You Ever Had Rheumatic Fever or Rheumatic Heart Disease?	___	___
Have You Ever Been Diagnosed as Having a Heart Murmur?	___	___
Have You Ever Been Told That You Have a Heart Valve Problem or Prolapsed Heart Valve?	___	___
Have You Ever Had Recurring Chest Pains or Angina?	___	___
Do You Have A Cardiac Pacemaker?	___	___
Do You Have Arteriosclerosis or Other Vascular Problems?	___	___
Do You Have Any Blood Problems or Anemia?	___	___

	YES	NO
Do You Have High or Low Blood Pressure?	___	___
Have You Ever Had a Stroke or CVA?	___	___
Have Your Ever Had Any Excessive Bleeding From Any Cut or Incident?	___	___
Have You Ever Had Any Seizures or Fainting Spells?	___	___
Have You Ever Been Diagnosed as Having Lupus?	___	___
Do You Have Arthritis?	___	___
Do You Have Any Artificial Joints or Prosthesis?	___	___
Have You Ever Had Any Lung Disorders or Tuberculosis?	___	___
Have You Ever Had Any Liver Problems or Hepatitis?	___	___
Do You Smoke or Chew Tobacco?	___	___
Have You Ever Had Any Form of Cancer?	___	___
Have You Ever Had Any Kidney Problems?	___	___
Have You Ever Had an Organ Transplant?	___	___
Do You Have Diabetes or Blood Sugar Problems?	___	___
Do You Have Glaucoma or Other Eye Problems?	___	___
Have You Ever Had a Thyroid Problem or Disease?	___	___
Have You Ever Had a Substance Abuse Problem?	___	___
Have You Ever Been Treated for Psychiatric Problems?	___	___
Have You Ever Tested Positive for HIV or AIDS?	___	___
Do You Presently Have Any Active Venereal Diseases?	___	___

Please Explain Any Condition, Disease, Situation or Problem That You Think Our Office Should Know About

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For Women Only:

Are You Presently Using a Birth Control Medication?	___	___
Are You Pregnant?	___	___
If Yes, What is your Due Date? _____		
Are You Presently Nursing?	___	___

APPOINTMENTS-A minimum charge will be made for failed or cancelled appointments without prior notification of at least 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved just for you. Any change in your appointments affects many patients; please be considerate.

CONSENT- To the best of my knowledge, all of the preceding answers are correct. If I every have any change in my health, or if my medications change, I will inform this office at the next appointment without fail. I hereby consent to allow diagnosis, proper dental care and treatment to be performed by this practice for myself or the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

SIGNATURE_____Date: _____
(Parent or Guardian, if Patient is a Minor)