

# HEALTH HISTORY

PATIENT NAME \_\_\_\_\_

1. Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_



MED  
ALERT

2. Are you allergic, or have you reacted adversely, to any of the following? Please circle.

Penicillin	Erythromycin	Clindamycin	Tetracycline	Aspirin
Codeine	Sulfa Drugs	Darvon	Demerol	Mint Flavoring
NSAID's (non Sterioidal anti inflammatory drugs)			Latex	Local Anaesthetic
Other _____				

3. Please list all medication you are taking now, including non-prescription medication such as vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.: \_\_\_\_\_

4. Do you have, or have you experienced, any of the following:

<i>Y N</i> Allergies/Hayfever	<i>Y N</i> Other Liver Disease	<i>Y N</i> Multiple Sclerosis	<i>Y N</i> Psychiatric Disorder
<i>Y N</i> Asthma	<i>Y N</i> Kidney Disease	<i>Y N</i> Parkinson's Disease	<i>Y N</i> Glaucoma
<i>Y N</i> Cold Sores	<i>Y N</i> Artificial Joints	<i>Y N</i> Lupus	<i>Y N</i> AIDS/HIV+
<i>Y N</i> Anemia	<i>Y N</i> Emphysema	<i>Y N</i> Arthritis	<i>Y N</i> Epilepsy
<i>Y N</i> Blood Transfusion	<i>Y N</i> Tuberculosis (TB)	<i>Y N</i> Chronic Fatigue Syndrome	<i>Y N</i> High Blood Pressure
<i>Y N</i> Hemophilia	<i>Y N</i> Other Lung Disease	<i>Y N</i> Sexually Transmitted Disease	<i>Y N</i> Scarlet Fever
<i>Y N</i> Hepatitis A (infectious)	<i>Y N</i> Ulcerative Colitis	<i>Y N</i> Diabetes	<i>Y N</i> Rheumatic Fever
<i>Y N</i> Hepatitis B (serum)	<i>Y N</i> Crohn's Disease	<i>Y N</i> Eating Disorder	
<i>Y N</i> Hepatitis C	<i>Y N</i> Ulcers	<i>Y N</i> Drug Addiction	

**Heart Disease:**

<i>Y N</i> Angina	<i>Y N</i> Stroke	<i>Y N</i> Heart Murmur
<i>Y N</i> Congestive Heart Failure	<i>Y N</i> Mitral Valve Prolapse	<i>Y N</i> Artificial Heart Valve/Stent
<i>Y N</i> Angioplasty	<i>Y N</i> Pacemaker	<i>Y N</i> Cardiopulmonary Shunt
<i>Y N</i> Heart Attack	When _____	

**Cancer:**

Where? \_\_\_\_\_ When? \_\_\_\_\_

*Y N* Radiation Therapy *Y N* Chemotherapy

- |   |     |    |
|---|-----|----|
| 5. Do you have any disease, condition or problem not listed?                                | yes | no |
| 6. Do you wish to speak privately to the doctor about any medical condition?                | yes | no |
| 7. Have you had a medical examination in the last year?                                     | yes | no |
| 8. Have you been a patient in the hospital in the last 2 years?                             | yes | no |
| 9. When walking up stairs or taking a walk, do you ever stop because of pain in your chest? | yes | no |
| 10. Do your ankles swell during the day?  | yes | no |
| 11. Do you have a tendency to faint?  | yes | no |
| 12. Do you have frequent, severe headaches?   | yes | no |
| 13. Do you use tobacco?   | yes | no |
| 14. Are you pregnant or possibly pregnant? If yes, what month? _____                        | yes | no |
| 15. Are you breastfeeding?  | yes | no |

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date