Full Name _____ Patient Account Number _____ **OFFICE USE**

PATIENT HEALTH HISTORY

Circle Yes or No

1. When was your last Dental Examination and Cleaning ? _____
2. Have you been a patient in the hospital during the past two (2) years? . . . . . Y / N
   If yes, please explain _____
3. Have you been under the care of a medical doctor during the past two (2) years? . . . . . Y / N
   If yes, please explain _____

   Physician's Name _____ Phone # ____ - ____ - ____

   Address _____

   City _____ State ____ ZIP _____
4. Have you taken any medicine or drugs during the past two (2) years? . . . . . Y / N
5. Are you now taking any prescribed or non-prescription medication, drugs or pills? . . . . . Y / N
   If yes, please list: _____

6. Are you allergic or have you reacted adversely to any of the following medications? (please circle YES or NO)

Aspirin	Y / N	Nitrous Oxide	Y / N	Valium	Y / N	Local Anesthetic	Y / N
Darvon	Y / N	Erythromycin	Y / N	Scopolamine	Y / N	(Novacaine/Xylocaine)	Y / N
Codeine	Y / N	Tetracycline	Y / N	Penicillin	Y / N	Sleeping Pills	Y / N
Demerol	Y / N	Percodan	Y / N	Other Antibiotics	Y / N	(Nembutal/Seconal)	Y / N

7. Are you aware of being allergic to any other medications, foods or substances . . . . . Y / N
   If yes, please list: _____

8. Have you had or do you have at present:

Heart Failure	Y / N	Emphysema	Y / N	A.I.D.S	Y / N
Heart Disease or attack	Y / N	Cough	Y / N	Hepatitis A (Infectious)	Y / N
Angina Pectoris	Y / N	Tuberculosis (TB)	Y / N	Hepatitis B (Serum)	Y / N
High Blood Pressure	Y / N	Asthma	Y / N	Liver Disease	Y / N
Heart Murmur	Y / N	Hay Fever	Y / N	Yellow Jaundice	Y / N
Rheumatic Fever	Y / N	Sinus Trouble	Y / N	Blood Transfusion	Y / N
Congenital Heart Lesions	Y / N	Allergies or Hives	Y / N	Drug Addiction	Y / N
Scarlet Fever	Y / N	Diabetes	Y / N	Hemophilia	Y / N
Artificial Heart Valve	Y / N	Thyroid Disease	Y / N	Cold Sores	Y / N
Heart Pacemaker	Y / N	X-Ray or Cobalt treatment	Y / N	Fever Blisters	Y / N
Heart Surgery	Y / N	Chemotherapy (Cancer/Leukemia)	Y / N	Epilepsy or Seizures	Y / N
Anemia	Y / N	Rheumatism	Y / N	Nervousness	Y / N
Stroke	Y / N	Cortisone Medicine	Y / N	Psychiatric Treatment	Y / N
Ulcers	Y / N	Pain in Jaw Joint	Y / N	Bruise Easily	Y / N
Cosmetic Surgery	Y / N	Abnormal Bleeding with previous extractions or surgery	Y / N	Venereal Disease (Syphilis, Gonorrhea)	Y / N

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired ? . . . . . Y / N
10. Do your ankles swell during the day? . . . . . Y / N
11. Do you use more than two (2) pillows to sleep ? . . . . . Y / N
12. Have you lost or gained more than ten (10) pounds of weight in the past year ? . . . . . Y / N
13. Do you ever wake up from sleep short of breath ? . . . . . Y / N
14. Are you on a special diet ? . . . . . Y / N
15. Has your medical doctor ever said you have a cancer or a tumor ? . . . . . Y / N

Please, complete other side also

16. Do you have any disease, conditions or problems not listed ? ..... Y / N
If yes, please explain: _____

17. Do you smoke ? ..... Y / N

18. Do you participate in any activity that would increase the possibility of HIV infection ? ..... Y / N

19. Have you ever had an HIV blood test ? ..... Y / N
If yes, please give date and results _____ _____

20. Have you ever experienced a sensitivity to Latex ? ..... Y / N

21. Have you taken or are you taking Bisphosphonates (Aridia, Fosamax, Actonel, Zomedia, Boniva,etc.) Y / N

22. Have you ever taken Fen-Phen or Redux ? ..... Y / N

23. Is there any other medical information you would like us to know ? ..... Y / N
If yes, please explain: _____
_____

For Women Only:

Are you pregnant? ☐ Yes ☐ No. If yes, what month ____. Are you taking birth control pills? ☐ Yes ☐ No

CONSENT

The undersigned hereby authorizes Doctor, after consultation with patient (or parent, if minor) to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents carries a certain risk.

I certify that the above information is true and correct:

_____ Date _____
PATIENT'S SIGNATURE or PARENT'S, IF MINOR CHILD

_____ Date _____
DOCTOR'S SIGNATURE

HEALTH HISTORY UPDATE

Health changes since last Dental Exam:_____
_____
_____
_____

Last Physical Exam:_____
Physician's Name: _____
Physician's Phone: (_____) _____

Date: _____ Patient Signature: _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____

Allergies? _____

Have you ever experienced sensitivity to Latex? Yes / No

Have you ever taken Fen-Phen or Redux? Yes / No

Doctor's Signature: _____

Health changes since last Dental Exam:_____
_____
_____
_____

Last Physical Exam:_____
Physician's Name: _____
Physician's Phone: (_____) _____

Date: _____ Patient Signature: _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____

Allergies? _____

Have you ever experienced sensitivity to Latex? Yes / No

Have you ever taken Fen-Phen or Redux? Yes / No

Doctor's Signature: _____