HEALTH HISTORY

Name _____ Date _____ Address_____ Town/Zip _____

Home phone _____ Work phone _____ Cell phone _____

Your SS# _____Marital status _____ Date of birth _____

Your occupation _____ Employer _____ E-mail_____

Spouse's name _____ Occupation _____ Employer _____

Person financially responsible _____ Insurance _____

How did you hear of our office? _____

Employee with Insurance _____ SS#_____ Date of birth _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

AIDS/HIV Positive	No	Yes	Heart Transplant	No	Yes
Alzheimer's Disease	No	Yes	Heart Pacemaker Year Placed	No	Yes
Anemia	No	Yes	Hepatitis A	No	Yes
Arthritis/Gout	No	Yes	Hepatitis B or C	No	Yes
Artificial Joint Year Placed	No	Yes	Hemophelia	No	Yes
Asthma	No	Yes	High Blood Pressure	No	Yes
Blood Disease	No	Yes	Low Blood Pressure	No	Yes
Cancer or Tumor	No	Yes	Hypoiglycemia	No	Yes
Chemo Therapy/Radiation Tx	No	Yes	Kidney Disease	No	Yes
Convulsions	No	Yes	Leukemia	No	Yes
Diabetes or Blood Sugar Problems	No	Yes	Liver Disease (including Jaundice)	No	Yes
Drug Addiction	No	Yes	Previous Biopsies	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Psychiatric Care	No	Yes
Epilepsy	No	Yes	Rheumatic Fever	No	Yes
Fainting or Dizzy Spells	No	Yes	Scarlet Fever	No	Yes
Glaucoma	No	Yes	Sinus Trouble	No	Yes
Hay Fever	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Stroke	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Thyroid Disease	No	Yes
Heart Stent? When placed?	No	Yes	Venereal Disease	No	Yes
Artificial Heart Valve	No	Yes	Other Conditions	No	Yes
			Recurrent Illnesses	No	Yes
			Have you had any serious illness not listed above?	No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Blood Pressure? If Known If taken if Office
What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics …….. No Yes
b. Penicillin …… No Yes
c. Aspirin …..……. No Yes
d. Codeine, …… ……. No Yes
e. Latex ……. No Yes
f. Metals…… No Yes
g. Other antibiotics…….. No Yes
h. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes
Have you attended alcohol or drug rehab in the last year?	No	Yes
(some of our medications WILL interact)		

Are you fearful of Dental Treatment?		No	Yes
Would you be interested in Nitrous Oxide for your dental treatment?		No	Yes
Would you be interested in some type of Sedation for your dental treatment?		No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

DOCTOR USE:
BASE BP: /
TONGUE: 1 2 3 4