HEALTH HISTORY NAME:_____

Are you allergic to any of the following?
___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics___ Other (Please list) _____

**List any medication you are currently taking:
_____

_____

Are you under physicians care now? ___ Y ___ N

Have you ever been hospitalized/major operation? ___ Y ___ N
If yes, please explain: _____

Have you ever had a serious head or neck injury? ___ Y ___ N
If yes, please explain: _____

Have you had any artificial joint/prosthetics in past 2 years? ___Y ___N

Are you taking any blood thinning medication? ___ Y ___ N
If yes, please explain: _____

Do you use tobacco? ___ Y ___N

Have you had a car accident in the last 5 years? ___Y ___N

Have you had psychiatric treatment? ___Y ___N

Do you have a pacemaker, an artificial heart valve or total joint replacement? ___Y ___N

Are you taking Fosamax, Zometa, Boniva or any other medication for osteoporosis? ___Y ___N

Do you regularly consume more than 2 alcoholic beverages in a day? ___ Y ___ N

Have you ever had any serious illness not listed above? If yes, please explain: ___Y ___N
_____

Women, are you:
Pregnant/Trying to get pregnant? ___ Y ___ N Taking oral contraceptives? ___ Y ___ N Nursing? ___ Y ___ N

Do you have or have you had any of the following? (please circle)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Cold Sores/Fever Blisters
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	**High/Low** Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle Cell Disease
Asthma	Fainting/Seizures	Kidney Problems	Stomach Trouble
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Congenital Heart Disorder	Lung Disease	Chest Pains
Cancer	Glaucoma	Tuberculosis	Heart Trouble/Disease
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growths
Heart Attack/Failure	Parathyroid Disease	Ulcers	
Psychiatric Care	Venereal Disease	Convulsions	
Radiation Treatments	Yellow Jaundice	Recent Weight Loss	

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

Signature of Patient/Guardian: _____ Date: _____