HEALTH HISTORY

Patient Name: _____Gender: _____

Do you have an allergy to any of the following?

Aspirin (NSAID) Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other (Please list) _____

List **ALL medication you are currently taking: _____

_____

_____

Are you under physicians care other than primary care? ___ Y ___ N
If yes, please explain: _____

Have you ever been hospitalized/major operation or a serious head/neck injury? ___ Y ___ N
If yes, please explain: _____

Have you had any artificial joint/prosthetics in past 2 years? ___Y ___N
If yes, are you taking a pre-med: _____

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

Do you use tobacco? ___Y ___ N

Do you or anyone in your family have a history of substance abuse? ___ 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 or an artificial heart valve? ___Y ___N

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

Have you been out of the country within the last 5 years? ___ Y ___ N

***Please note: Our treatment chairs have a weight limit of 350-400 pounds. If this restriction is a concern, please let us know.**

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	Coronavirus/ COVID-19	Hepatitis A	Rheumatism
Alzheimer's/Dementia	Cortisone Medications	Hepatitis B or C	Scarlet Fever
Anaphylaxis	Diabetes	Herpes	Shingles
Anemia	Drug Addiction	**High** Blood Pressure	Sickle Cell Disease
Angina	Emphysema	Hives or Rash	Sinus Issues
Arthritis/Gout	Epilepsy/Seizures	Kidney Disease	Sjogren's Syndrome
Asthma	Fainting	Leukemia	Stomach Problems
Blood Disease	Frequent Cough	Liver Disease	Stroke
Blood Transfusion	Frequent Diarrhea	**Low** Blood Pressure	Swelling of Limbs
Breathing Problem	Frequent Headaches	Lung Disease	Thyroid Disease
Bruises Easily	Gag Reflex	Pain in Jaw Joints	Tuberculosis
Cancer	Glaucoma	Parathyroid Disease	Tumor or Growths
Chemotherapy	Hay Fever	Psychiatric Care	Ulcers
Chest Pains	Heart Attack/Failure	Radiation Treatment	Venereal Disease
Cold Sores/Fever Blisters	Heart Disease	Recent Weight Loss	Yellow Jaundice
Congenital Heart Disorder	Hemophilia	Renal Dialysis	**Others:**

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. A fee of $150 per scheduled hour with doctor and $100 with hygienist will be charged for appointments that are missed or canceled without 48-hour notice.

Signature of Patient/Guardian: _____ **Date:** _____