Health History

Family Physician _____ Office Phone _____ Date of last exam _____

When were you last seen by a dentist _____ Date of last exam _____

Please check yes/no

	Y	N
Are you taking any medications Including non-prescription medicine? If so, please list. _____ _____	☐	☐
Allergies		
Local Anesthetics (e.g. Novacaine)	☐	☐
Penicillin	☐	☐
Other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Other	☐	☐
Do you have any of the following?		
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
Other Heart Trouble	☐	☐
Low Blood Pressure	☐	☐
Cardiac Pacemaker	☐	☐
Chest Pain	☐	☐
Stroke	☐	☐
Easily Winded	☐	☐
Swollen Ankles	☐	☐
Angina	☐	☐
Leukemia	☐	☐
Cancer	☐	☐
Kidney Disease	☐	☐
Thyroid Problems	☐	☐
Liver Disease	☐	☐
Emphysema	☐	☐

	Y	N
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Do you use Tobacco?	☐	☐
Do you use Drugs?	☐	☐
Do you use Alcohol?	☐	☐
Are you wearing contact lenses?	☐	☐
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐
Have you ever been pre-medicated to go to a dentist? (if so, do you presently need to?)	☐	☐
Have you had a Mitral Valve Prolapse?	☐	☐
Have you had Rheumatic Fever?	☐	☐
Have you had a Heart Murmur?	☐	☐
Have you had a Hip or Joint Replacement	☐	☐
Asthma	☐	☐
Hay Fever/Allergies	☐	☐
Respiratory Problems	☐	☐
Fainting/Seizures	☐	☐
Epilepsy/Convulsions	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Anemia	☐	☐
Tuberculosis	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Radiation Therapy	☐	☐
Recent Weight Loss	☐	☐
Glaucoma	☐	☐
Arthritis	☐	☐
Other	☐	☐

Do you have any problems with your teeth such as, bleeding gums, sensitive to hot/cold, sweet/sour or liquids/foods?	☐	☐
Do you feel any pain in any of your teeth, jaw, or head?	☐	☐
Have you ever experienced problems with clicking, pain, difficulty opening or closing or chewing, grinding, or clenching your teeth?	☐	☐
Have you ever had difficulty or prolonged bleeding after teeth extractions?	☐	☐
Have you ever had instruction on the correct way to care for your teeth and gums?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient/Responsible Party _____ Date _____

Doctor's Comments _____

Doctor's Signature _____ Date _____