

# HEALTH HISTORY

NAME \_\_\_\_\_

Do you have a personal physician?  Yes  No

Physicians name \_\_\_\_\_

Phone # \_\_\_\_\_ Last visit \_\_\_\_\_

In the event of an emergency, who do we call:

Name \_\_\_\_\_

Relation \_\_\_\_\_

Home # \_\_\_\_\_

Office # \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Which condition/s? \_\_\_\_\_

Have you had any RECENT SURGERY?  Yes  No

## MEDICATIONS

Are you currently taking prescription or over-the-counter drugs or herbal supplements?  Yes  No

Please list here: \_\_\_\_\_

Are you on aspirin therapy?  Yes  No

Do you take Ginger, Ginseng, Ginko Biloba, and/or Garlic?  Yes  No

Which? \_\_\_\_\_

*Attach separate list if necessary*

Pharmacy name and phone #: \_\_\_\_\_

## ALLERGIES: Please check if you have

Aspirin  Local Anesthetic

Codeine  Penicillin

Latex  Sulfa

Erythromycin

Others \_\_\_\_\_

Do you require premedication with antibiotics before dental treatment?

Yes or  No

For what condition \_\_\_\_\_

Do you or have you ever used:

Tobacco? Frequency \_\_\_\_\_

Alcohol? Frequency \_\_\_\_\_

Controlled substances? Frequency \_\_\_\_\_

## WOMEN ONLY

Are you pregnant?  Yes  No Week \_\_\_\_\_

Are you taking birth control pills?  Yes  No

Are you nursing?  Yes  No

Hormone Replacement therapy  Yes  No

## Please check if you have:

- AIDS/HIV
- ANEMIA
- ARTHRITIS OR RHEUMATISM
- ARTIFICIAL HEART VALVES
- ARTIFICIAL JOINTS
- ASTHMA
- BACK PROBLEMS
- BLEEDING ABNORMALLY
- BLOOD DISEASE
- CANCER
- CHEMICAL DEPENDENCY
- CHEMOTHERAPY
- CIRCULATORY PROBLEMS
- CONGENITAL HEART LESIONS
- CORTISONE TREATMENTS
- COUGH, PERSISTANT OR BLOODY
- CROHN'S DISEASE/INFLAMMATORY BOWEL DISEASE
- DIABETES
- EMPHYSEMA
- EPILEPSY
- FAINTING OR DIZZINESS
- GLAUCOMA
- HEADACHES
- HEART MURMUR
- HEART PROBLEMS
- HEPATITIS, TYPE \_\_\_\_\_
- HERPES
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- IRRITABLE BOWEL DISORDER
- JAUNDICE
- JAW PAIN
- KIDNEY DISEASE
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MITRAL VALVE PROLAPSE
- MULTIPLE SCLEROSIS
- NERVOUS PROBLEMS
- OSTEOPOROSIS/MEDICATIONS
- PACEMAKER
- PROSTATE PROBLEMS
- PSYCHIATRIC CARE
- RADIATION TREATMENT
- RESPIRATORY DISEASE
- RHEUMATIC FEVER
- SCARLET FEVER
- SHORTNESS OF BREATH
- SINUS TROUBLE
- SKIN RASH
- SPECIAL DIET
- STROKE
- SWOLLEN FEET OR ANKLES
- SWOLLEN NECK GLANDS
- THYROID PROBLEMS
- TMJ PROBLEMS (JAW JOINT)
- TONSILLITIS
- TUBERCULOSIS
- TUMOR OR GROWTH ON HEAD OR NECK
- ULCER
- VENEREAL DISEASE
- WEIGHT LOSS, UNEXPLAINED

The information on this two-page registration/health history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_