Health History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, any medications you may be taking, could have an important relationship with the dentistry you will receive; Thank you for answering the following questions.

Are you under a physicians care now?	**Y**	**N**	**If yes, Please explain, _____**
Have you ever been hospitalized / major operation?	**Y**	**N**	**If yes, Please explain, _____**
Have you ever had a serious head/ neck injury, or radiation?	**Y**	**N**	**If yes, Please explain, _____**
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	**Y**	**N**	**If yes, Please explain, _____**
Do you use tobacco (including smokeless, vaping, etc.) or marijuana?	**Y**	**N**	**If yes, Please explain, _____**
Are you required to take antibiotics prior to dental appts?	**Y**	**N**	**If yes, Please explain, _____**
Are you diabetic?	**Y**	**N**	**If yes, what was your last A1C? _____**

Are you taking any medications, pills or drugs, or OTC supplements? _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: _____

Do you have, or have you had, any of the following?

AIDS/ HIV	Hemophilia / Excessive Bleeding	Pregnancy
Alzheimer's Disease	Hepatitis A, B, or C	Heart Murmur
Anaphylaxis	Drug Addiction	Infectious Disease
Anemia	Rheumatic Fever	Heart Murmur
Angina	Scarlet Fever	GERD / Acid Reflux
Arthritis/Gout / Rheumatism	Sleep Apnea	Tuberculosis
Artificial Heart Valve	Shingles	Organ Transplant
Artificial Joint	Hypoglycemia	Ulcers
Asthma	Fainting Spells/Dizziness	Sinus Trouble
Blood Disease or Transfusion	Kidney Disease / Dialysis	Osteoporosis
Stomach/Intestinal Disease	Liver Disease	Congenital Heart Disorder
Stroke	Thoughts of suicide	Pain in Jaw Joints
Cortisone Medicine	Heart Pacemaker	Convulsions / Seizures
High / Low Blood Pressure	Cold Sores/Fever Blisters	Parathyroid / Thyroid Disease
Cancer / Tumors	Glaucoma	Psychiatric Care
Lung Disease	Heart Trouble/Disease	Yellow Jaundice
Chemotherapy	Mitral Valve Prolapse	Hay Fever

Have you ever had a serious illness not listed above? _____

Comments: _____

Signature of patient or guardian: _____ Date: _____