Health History Form

Patient Name: _____ Birth Date: _____ Date Created: _____

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

General Questions:

Are you under a physician's care now? □ Yes □ No If Yes: _____

Have you ever been hospitalized or had a major operation? □ Yes □ No If Yes: _____

Have you ever had a serious head or neck injury? □ Yes □ No If Yes: _____

Are you taking any medications, pills, or drugs? □ Yes □ No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or or any other medications containing bisphosphonates? □ Yes □ No If Yes: _____

Do you use tobacco? □ Yes □ No

Women: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

Do you use controlled substances or marijuana? □ Yes □ No If Yes: _____

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

	Yes		Yes		Yes		Yes
AIDS/HIV Positive	□	Cortisone Medicine	□	Alzheimer's Disease	□	Diabetes	□
Hepatitis A	□	Hepatitis B or C	□	Renal Dialysis	□	Anemia	□
Herpes	□	Rheumatic Fever	□	Angina	□	Emphysema	□
High Blood Pressure	□	Epilepsy or Seizures	□	High Cholesterol	□	Scarlet Fever	□
Artificial Heart Valve	□	Excessive Bleeding	□	Hives or Rash	□	Shingles	□
Artificial Joint	□	Excessive Thirst	□	Sickle Cell Disease	□	Asthma	□
Fainting Spells/Dizziness	□	Irregular Heartbeat	□	Blood Disease	□	Kidney Problems	□
Blood Transfusion	□	Leukemia	□	Stomach/Intestine Disease	□	Frequent Headaches	□
Liver Disease	□	Stroke	□	Bruise Easily	□	Low Blood Pressure	□
Cancer	□	Glaucoma	□	Lung Disease	□	Thyroid Disease	□
Chemotherapy	□	Mitral Valve Prolapse	□	Chest Pains	□	Heart Attack/Failure	□
Osteoporosis	□	Tuberculosis	□	Cold Sores/Fever Blisters	□	Heart Murmur	□
Pain in Jaw Joints	□	Tumors or Growths	□	Congenital Heart Disorder	□	Heart Pacemaker	□
Parathyroid Disease	□	Ulcers	□	Convulsions	□	Heart Trouble/Disease	□
Psychiatric Care	□	Venereal Disease	□				

Have you ever had any serious illness not listed? □ Yes □ No If Yes:
_____

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date:
_____