HEALTH HISTORY

Patient's name_____ Date of Birth_____

Do you have, or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ AIDS or HIV positive
- ❑ Allergies
- ❑ Arthritis
- ❑ Artificial joint or valves
- ❑ Asthma
- ❑ Blood Problems or Anemia
- ❑ Blood transfusion
- ❑ Bone or joint problems
- ❑ Cancer/Tumor
- ❑ Chemical Dependency
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Hayfever or sinus trouble
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Heart problems
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Respiratory disease
- ❑ Radiation Treatment
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis or other lung problems

Women:
- ❑ Pregnant or plan to become pregnant
- ❑ Taking hormones or contraceptives

❑ **Are you required to Pre-medicate before any dental treatment?**

Are you allergic to, or have you reacted adversely to any of the following?
- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine
- ❑ Latex
- ❑ Local anesthetics
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Other: _____

_____

Are you taking any of the following?
- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Osteoporosis (bone density) medicine
- ❑ Other- Please list all medications you are taking

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❑ **Do you smoke, vape or use tobacco?**

Name of your primary medical Physician_____Phone Number_____

Signature of patient (or parent) _____ Date _____