Health Information _____ (patient's name)

Have you ever had any of the following? Please check all that apply.

- ☐ AIDS/HIV+
- ☐ Allergies _____
- ☐ Allergies to Medications _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Surgery Date: _____
- ☐ Asthma/Emphysema
- ☐ Blood Disease
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease Surgery Date: _____
- ☐ Heart Valves, Damaged or Repaired Surgery Date: _____
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ OTHER: _____ _____ _____ _____ _____ _____ _____ _____ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been treated for a serious illness or operation? ☐ Yes ☐ No
  If yes, please explain: _____
- Did you receive a blood transfusion prior to 1985? ☐ Yes ☐ No
- Have you ever been instructed by your physician to pre-medicate with an antibiotic prior to dental treatment?
  ☐ Yes ☐ No Name of Medication _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
  _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- **For Women Only:** Are you currently pregnant? ☐ Yes ☐ No

To the best of my knowledge, all of the above answers and information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian