

## Health History

Last Name		First Name			MI	Date
Address		Apt. No.			Home Phone	
City, State			Zip Code		Work Phone	
Reason for Your Visit					Cell Phone	
Male	Female	Married	Single	Child	Other	
					Date of Last Dental Visit	
Previous Dentist's Name		City, State			Did you bring your records?	

## Check Those That Apply to You

AIDS	Emphysema	Latex Allergy or Sensitivity	Tobacco Use
Allergies (list)	Epilepsy	Liver Disease	Tuberculosis
Anemia	Excessive Bleeding	Mental Disorder	Tumors
Arthritis	Fainting	Mitral Valve Prolapse	Ulcers
Artificial Joints	Glaucoma	Nervous Disorder	Venereal Disease
Artificial Heart Valve	Growths	Pacemaker	
Asthma	Hay Fever	Psychiatric/Psychological Care	<b>List Medication Allergies</b>
Blood Disease	HIV Positive	Pregnancy (due date:	
Bruise Easily	Head Injuries	Radiation Treatment	
Cancer	Heart Problems (attack, disease, surgery)	Respiratory Problems	
Cold Sores/Fever Blisters	Heart Murmur	Rheumatic Fever	
Contact Lenses	Hemophilia	Rheumatism	
Cortisone Medication	Hepatitis	Sinus Problems	
Diabetes	High Blood Pressure	Stomach Problems	
Diet (Restricted)	Jaundice	Stroke	
Dizziness	Kidney Disease	Thyroid Problems	

## General Health Questions

Have you experienced problems after dental treatment in the past? If so, explain.
Do you have any chronic dental or gum problems?
Are you experiencing oral pain? If so, explain.
Are you taking medications regularly? If so, list them here.
Have you been admitted to a hospital or emergency room in the past 24 months?
Are you currently under a physician's care? If so, please give your doctor's name and phone number.

By signing below, you verify that all of the information provided in this form is accurate and true to the best of your knowledge. You also agree to inform us if any of this information changes in the future.

Signature \_\_\_\_\_

Date \_\_\_\_\_