Health History

SSN: ____-____-______
Name: ___________________________________ M F (circle one) Date: ________________
Address: _________________________________ City: ___________ Zip: _______ D.O.B.: __________

Phone: (Home)____________(Work)____________(Cell)______________ Referred By:______________

Please answer all questions by circling **YES** or **NO** or by filling in the appropriate information. Your answers are for our records and are considered strictly confidential.

1. Have you been under a physician's care in the past 12 months? YES NO
*If yes please explain.*____
2. Have you ever been hospitalized or had any major medical problems? YES NO
*If yes please explain.*____
3. Physician's name and address:____
4. Date of last exam:____

5. Have you ever had a history of or do you now have any of the following diseases or problems?

A.	Heart condition………………..	YES	NO	R.	Thyroid………………….	YES	NO
B.	Heart surgery…………………..	YES	NO	S.	TB(tuberculosis)…………	YES	NO
C.	Rheumatic fever……………….	YES	NO	T.	Cancer……………………	YES	NO
D.	Heart Murmur………………….	YES	NO	U.	Lung Disease…………….	YES	NO
E.	Chest Pains…………………….	YES	NO	V.	Hives, skin rash…………	YES	NO
F.	High blood pressure…………...	YES	NO	W.	Swelling ankles…………	YES	NO
G.	Low blood pressure……………	YES	NO	X.	Fainting spells…………..	YES	NO
H.	Shortness of breath…………….	YES	NO	Y.	Seizures………………….	YES	NO
I.	Asthma, emphysema…………...	YES	NO	Z.	TD(Venereal disease)……	YES	NO
J.	Radiation Therapy……………...	YES	NO	AA.	Glaucoma………………	YES	NO
K.	Liver Disease…………………..	YES	NO	BB.	Allergies…………………	YES	NO
L.	Jaundice………………………..	YES	NO	CC.	Prosthetic joint replacement...	YES	NO
M.	Hepatitis………………………..	YES	NO	DD.	Latex Allergy……………	YES	NO
N.	Anemia…………………….........	YES	NO	EE.	HIV positive, AIDS………	YES	NO
O.	Other blood disorders………….	YES	NO	FF.	Known exposure to HIV…	YES	NO
P.	Diabetes………………………..	YES	NO	GG.	Skin reaction to jewelry….	YES	NO

6. Are you taking any medications? YES NO
*If so what?*____
7. Are you taking Bisphosphonates? YES NO ____
8. Are you allergic to or have you reacted adversely to any medication? YES NO
*If so what?*____
9. Have you ever had an adverse reaction to local anesthetic (Lidocaine/Novocaine)? YES NO
10. Do you have any disease, condition, or problem not listed above that you feel we should know about? Y N
*If so what?*____

Woman: Dental Questions:

1. Are you pregnant?... YES NO
2. Have you had complications with pregnancy?. YES NO
3. Are you nursing?... YES NO
4. Are you taking any oral contraceptives?.......... YES NO

Are you having a dental problem? Y N
*If so what?*________________________
If there something you could change about your smile what would it be? _______
____

Please Sign Below:

Patients Signature:__________________________________ Last Dental Visit:______________________