## 5 HEALTH HISTORY

Physician's Name: ______________________ Date of Last Visit: __________

| | Yes | No |
|---|---|---|
| AIDS / HIV | ☐ | ☐ |
| ANEMIA | ☐ | ☐ |
| Arthritis, Rheumatism | ☐ | ☐ |
| Artificial Heart Valves | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Back Problems | ☐ | ☐ |
| Bleeding abnormally, with extractions or surgery | ☐ | ☐ |
| Blood Disease | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ |
| Cortisone Treatments | ☐ | ☐ |
| Cough, persistent or bloody | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Fainting or Dizziness | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Heart Problems | ☐ | ☐ |
| Hepatitis Type ________ | ☐ | ☐ |
| Herpes | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Jaw Pain | ☐ | ☐ |
| Joint Replacement | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Nervous Problems | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Psychiatric Care | ☐ | ☐ |
| Radiation Treatment | ☐ | ☐ |
| Respiratory Disease | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Skin Rash | ☐ | ☐ |
| Special Diet | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Swollen Feet or Ankles | ☐ | ☐ |
| Swollen Neck Glands | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |
| Tonsillitis | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Tumor or Growth on Head or Neck | ☐ | ☐ |
| Ulcer | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ |
| Others | ☐ | ☐ |

Comments: ______________________

**If yes to any of the starred conditions, please call prior to your appointment . . . Premedication may be required.*

| | Yes | No |
|---|---|---|
| Do you use tobacco products? | ☐ | ☐ |
| If yes, what and how often? ______________ | | |
| Do you use antidepressants or sleeping pills? | ☐ | ☐ |
| If yes, list name(s) ______________ | | |

Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?
If yes, please explain ______________

| | Yes | No |
|---|---|---|
| Are you on any blood thinners, including aspirin? | ☐ | ☐ |

If yes, what? ______________

### Women:

| | Yes | No |
|---|---|---|
| Are you pregnant? | ☐ | ☐ |
| If yes, when is your due date? ______________ | | |
| Taking birth control pills? | ☐ | ☐ |
| Are you taking hormones? | ☐ | ☐ |

### MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

______________________

______________________

______________________

______________________

Pharmacy Name: ______________

Phone: (_____) ______________

### ALLERGIES

- ☐ No Allergies
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and team at the next appointment without fail.

Patient (Responsible Party) Signature **X** ______________________ Date __________