Health History 2021

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever had a major operation?	◯ Yes ◯ No	If yes
Do you Smoke or Chew Tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes

Medication List

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Erythromycin			

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No

Are you Pregnant?	◯ Yes ◯ No	
Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes

Comments

Authorization and Release:
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I authorize release of my or (my child's) information for the purpose of evaluation and administering claims to insurance, for advice and/or treatment to another dentist or medical information from my(or child's) physician. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services not paid by the insurance. I understand it is my repsonsibility to inform the dental office of any changes in medical status, Dental Insurance or Address.

Signature of Patient, Parent or Guardian:

X Date:_____