

HEALTH HISTORY

Do you have a personal physician? Yes No

Physicians name _____

Phone # _____ Last visit _____

In the event of an emergency, who do we call:

Name _____

Relation _____

Home # _____

Office # _____

Are you currently under the care of a physician? Yes No

Which condition/s? _____

Have you had any RECENT SURGERY? Yes No

MEDICATIONS

Are you currently taking prescription or over-the-counter drugs or herbal supplements? Yes No

Please list here: _____

Are you currently taking Bis-Phosphonates? _____

Are you currently on a blood thinner? _____

Attach separate list if necessary

Pharmacy name and phone #: _____

ALLERGIES: Please check if

Aspirin Local Anesthetic

Codeine Penicillin

Latex Sulfa

Erythromycin

Others _____

Do you require premedication with antibiotics before dental treatment?

Yes or No

For what condition _____

Do you or have you ever used:

Tobacco? Frequency _____

Alcohol? Frequency _____

Controlled substances? Frequency _____

WOMEN ONLY

Are you pregnant? Yes No Week _____

Are you taking birth control pills? Yes No

Are you nursing? Yes No

Hormone Replacement therapy Yes No

Have you had a Pap Smear? Yes No

Please check if you have or have had in the past:

- AIDS/HIV
- ANEMIA
- ARTHRITIS OR RHEUMATISM
- ARTIFICIAL HEART VALVES
- ARTIFICIAL JOINTS
- ASTHMA
- BACK PROBLEMS
- BLEEDING ABNORMALLY
- BLOOD DISEASE
- CANCER
- CHEMICAL DEPENDENCY
- CHEMOTHERAPY
- CIRCULATORY PROBLEMS
- CONGENITAL HEART LESIONS
- CORTISONE TREATMENTS
- COUGH, PERSISTANT OR BLOODY
- CROHN'S DISEASE/INFLAMMATORY BOWEL DISEASE
- DIABETES (Please state type 1 or 2 if so)
- EMPHYSEMA
- EPILEPSY
- FAINTING OR DIZZINESS
- GLAUCOMA
- HEADACHES
- HEART MURMUR
- HEART PROBLEMS
- HEPATITIS, TYPE _____
- HERPES
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- IRRITABLE BOWEL DISORDER
- JAUNDICE
- JAW PAIN
- KIDNEY DISEASE
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MITRAL VALVE PROLAPSE
- MULTIPLE SCLEROSIS
- NERVOUS PROBLEMS
- OSTEOPOROSIS/MEDICATIONS
- PACEMAKER
- PROSTATE PROBLEMS
- PSYCHIATRIC CARE
- RADIATION TREATMENT
- RESPIRATORY DISEASE
- RHEUMATIC FEVER
- Sleep Apnea (Do you use a C-Pap or B-PAP?)
- SHORTNESS OF BREATH
- SINUS TROUBLE
- SKIN RASH
- SPECIAL DIET
- STROKE
- SWOLLEN FEET OR ANKLES
- SWOLLEN NECK GLANDS
- THYROID PROBLEMS
- TMJ PROBLEMS (JAW JOINT)
- TONSILLITIS
- TUBERCULOSIS
- TUMOR OR GROWTH ON HEAD OR NECK
- ULCER
- VENEREAL DISEASE
- WEIGHT LOSS, UNEXPLAINED
- PARKINSON'S
- HISTORY OF ORAL CANCER
- GOUT
- BENIGN ESSENTIAL TREMOR
- HPV HUMAN PAPILLOMA VIRUS
- AUTO-IMMUNE DISORDERS

The information on this three-page registration/health history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____