Health History

Person to Contact in Case of Emergency

Name: _____Relation_____
Work phone #:___-____-_____ Home phone #: ____-____-_____
Address: _____
City_____State____Zip_____

Physician: _____Phone #: _____Date of last visit:__/__/____
Are you currently under the care of a Physician?_____Yes_____No
Please explain: _____
_____

Your current health is_____Good_____Fair_____Poor

Do you smoke or use any form of tobacco? _____Yes _____No
Do you have any metal rods, pins or implants? _____Yes _____No
Do you take any herbal supplements? ____Yes ____No
Please list: _____
Do take or have you ever taken Fosamax or any other bisphosphonate? ____Yes ____No
Have you been told that you snore or hold your breath when you sleep? ____Yes ____No

For Women: Are you pregnant? ____Yes ____No number of weeks? _____
Are you nursing? ____Yes ____No
Are you using a prescribed method of birth control? ____Yes ____No

Do you or have you ever had any of the following?
Circle all that apply:

Abnormal Bleeding	Glaucoma	Pacemaker
Alcohol/ Drug Abuse	Hay Fever	Psychiatric Treatment
Anemia	Heart Attack	Radiation Treatment
Arthritis	Heart Murmur	Rheumatic Fever
Artificial Bone/ Joints/ Value	Heart Surgery	Seizures
Asthma	Hemophilia	Shingles
Blood Transfusion	Hepatitis	Sickle Cell Disease/Traits
Cancer/ Chemotherapy	Herpes/Fever Blisters	Sinus Problems
Colitis	High Blood Pressure	Stroke
Congenital Heart Defect	HIV+/ AIDS	Thyroid Problems
Diabetes	Kidney Problems	Tuberculosis
Difficulty Breathing	Liver Disease	Ulcers
Emphysema	Low Blood Pressure	Venereal Disease
Epilepsy	Lupus	Other: _____
Fainting Spells	Mitral Valve Prolapse	Hospitalized for any Reason
Frequent Headaches	Osteoporosis/ Paget's Disease	_____

List any serious medical conditions that you have had.

_____
_____
_____

Are you allergic to any of the following?
Circle all that apply

Aspirin	Latex
Codeine	Penicillin
Dental Anesthetics	Tetracycline
Erythromycin	Other: _____

Please list any other drugs or materials that you are allergic to:

_____
_____

Current Medications

Please list all current medication, prescription or over the counter

_____
_____
_____
_____
_____

Dental History

What brings you to the dentist today?

_____
_____

Do you require antibiotics prior to dental treatment? ____Yes ____No
Are you currently in dental pain? ____Yes ____No
Have you ever had a serious/difficult problem associated with previous dental work?
____Yes ____No
Do you have fears about going to the dentist?? ____Yes ____No
Have you ever had gum treatments? ____Yes ____No
Have you ever had treatment for TMJ or do you have discomfort in your jaw joint?
____Yes ____No
Do you like your smile? ____Yes ____No