PLEASE PRINT THIS FORM, FILL OUT AND BRING WITH YOU TO OFFICE

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years?
   Physician's Name _____
   Address _____ Phone # _____
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO
   If yes, please list: _____
8. Are you taking blood thinner? ..... YES NO
9. Have you received IV bone strengtheners or bisphosphonates? ..... YES NO
10. Are you taking oral bone strengtheners or bisphosphonates? ..... YES NO
    If yes, please list: _____
11. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO
    If yes, please list: _____
12. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES NO	Emphysema	YES NO	Hepatitis A (infectious)	YES NO
Heart Disease or Attack	YES NO	Cough	YES NO	Hepatitis B (serum)	YES NO
Angina Pectoris	YES NO	Tuberculosis (TB)	YES NO	Hepatitis C	YES NO
High Blood Pressure	YES NO	Asthma	YES NO	Liver Disease	YES NO
Heart Murmur	YES NO	Hay Fever	YES NO	Yellow Jaundice	YES NO
Rheumatic Fever	YES NO	Sinus Trouble	YES NO	Blood Transfusion	YES NO
Congenital Heart Lesions	YES NO	Allergies or Hives	YES NO	Drug Addiction	YES NO
Scarlet Fever	YES NO	Diabetes	YES NO	Hemophilia	YES NO
Artificial Heart Valve	YES NO	Thyroid Disease	YES NO	Venereal Disease	YES NO
Heart Pacemaker	YES NO	X-Ray or Cobalt Treatment	YES NO	Cold Sores	YES NO
Heart Surgery	YES NO	Chemotherapy (Cancer, Leukemia)	YES NO	Fever Blisters	YES NO
Artificial Joints (Hip, Knee)	YES NO	Arthritis	YES NO	Epilepsy or Seizures	YES NO
Anemia	YES NO	Rheumatism	YES NO	Fainting or Dizzy Spells	YES NO
Stroke	YES NO	Cortisone Medicine	YES NO	Nervousness	YES NO
Kidney Trouble	YES NO	Glaucoma	YES NO	Psychiatric Treatment	YES NO
Ulcers	YES NO	Pain in Jaw Joints	YES NO	Sickle Cell Disease	YES NO
Cosmetic Surgery	YES NO	A.I.D.S.	YES NO	Bruise Easily	YES NO

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in you chest, or shortness of breath, or because you are very tired? ..... YES NO
14. Do your ankles swell during the day? ..... YES NO
15. Do you use more that 2 pillows to sleep? ..... YES NO
16. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
17. Do you ever wake up from sleep short of breath? ..... YES NO
18. Are you on a special diet? ..... YES NO
19. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
20. Do you have any disease, condition, or problem not listed? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? Yes ☐ No ☐ If yes, what month? _____ Are you taking birth control pills? Yes ☐ No ☐

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT**

I have received a copy of this office's Notice of Privacy Practices

_____
Please Print Name

_____
Signature

_____
Date

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____