HEALTH HISTORY

Name of Primary Physician: _____Phone:_____

Are you under the care of a physician? ___Yes ___No

What are you currently being treated for? _____

Have you been admitted to a hospital or needed emergency care during the past two years? __Yes __No

If Yes, what for? _____

List any medications you are currently taking:_____

_____

List any medications your are ALLERGIC to: _____

Anything you feel you need to share with the Dr. _____

If you are pregnant or you think at any future appointment you may be pregnant, please let us know.

Have you ever had any of the following? Please check those that apply:

__ AIDS/HIV	__ Dizziness	__ Hepatitis	__ Penicillin Allergy
__ Anemia	__ Epilepsy	__ High Blood Pressure	__ Arthritis
__ Excessive Bleeding	__ Jaundice	__ Artificial Joints	__**Pregnant**
__ Kidney Disease	__ Radiation Treatment		Due Date _____
__ Asthma	__ Glaucoma	__ Liver Disease	__ Respiratory Problems
__ Blood Disease	__ Hay Fever	__ Mental Disorders	__ Rheumatic Fever
__ Cancer	__ Head Injuries	__ Metal or Latex Allergy	__ Sinus Problems
__ Codeine Allergy	__ Heart Disease	__ Other Allergies:	__ Stomach Problems
__ Diabetes	__ Heart Murmur	_____	__ Stroke
__ Tuberculosis	__ Tumors	__Other _____	

- Have you taken fen-phen? __ Yes __ No
- Do you have any health problems that need clarification __ Yes __ No

DENTAL HISTORY

- Have you ever had any complications following dental treatment? __ Yes __ N
- Are you having pain or discomfort at this time? __ Yes __No
- Are you nervous or apprehensive about your dental treatment? __ Yes __No
- Are you unhappy with the appearance of your teeth? __ Yes __No
- Have you ever had an unusual reaction to dental anesthetic? __ Yes __No

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

_____ _____

Signature of Patient, Parent or Guardian **Date**