HEALTH HISTORY

NAME _____

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 on aspirin therapy? ☐ Yes ☐ No

Do you take Ginger, Ginseng, Ginko Biloba, and/or Garlic? ☐ Yes ☐ No

Which? _____

Attach separate list if necessary

Pharmacy name and phone #:

_____

_____

ALLERGIES: Please check if

☐ Aspirin
☐ Codeine
☐ Latex
☐ Erythromycin
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ 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
☐ 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
☐ SCARLET FEVER
☐ 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 infomation on this two-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 _____