Health History

Patient Name: _____ Birth Date: _____

Do you have any dental concerns?	◯Yes	◯No	If yes, explain: _____
Are you under a physician care now?	◯Yes	◯No	If yes, explain: _____
Have you been hospitalized in past 2 years?	◯Yes	◯No	If yes, explain: _____
Have you ever had a serious head/neck injury?	◯Yes	◯No	If yes, explain: _____
Have you ever taken a Bisphosphonate (e.g. Prolia, Risedronate, Fosamax, Boniva, etc)	◯Yes	◯No	If yes, explain: _____
Are you on a special diet?	◯Yes	◯No	If yes, explain: _____
Do you use tobacco?	◯Yes	◯No	If yes, explain: _____
Do you use controlled substances?	◯Yes	◯No	If yes, explain: _____
Do you clench or grind your teeth?	◯Yes	◯No	If yes, do you wear a Night Guard?_____

Women are you...
Pregnant/Trying to get pregnant? ___Yes ___No Taking Birth Control Pills? ___ Yes ___No Nursing? ____Yes ___No

Are you allergic to any of the following?
☐ Penicillin/Amoxicillin ☐ Local Anesthetic ☐ Acrylic ☐ Metal

Do you have any of the following?

AIDS/HIV	◯Yes	◯No	Drug Addiction	◯Yes	◯No	Liver Disease	◯Yes	◯No
Alzheimer's/Dementia	◯Yes	◯No	Epilepsy or Seizures	◯Yes	◯No	Jaundice	◯Yes	◯No
Anemia/Excessive Bleeding	◯Yes	◯No	Fainting Spells/Dizziness	◯Yes	◯No	Low Blood Pressure	◯Yes	◯No
Angina/Chest Pain	◯Yes	◯No	Frequent Headaches	◯Yes	◯No	Lung Disease/Emphyse	◯Yes	◯No
Axiety	◯Yes	◯No	G.E.R.D.	◯Yes	◯No	Osteoporosis	◯Yes	◯No
Artificial Heart Valve	◯Yes	◯No	Hay Fever	◯Yes	◯No	Psychiatric Care	◯Yes	◯No
Artificial Joint	◯Yes	◯No	Heart Attack	◯Yes	◯No	Radiation Treatment	◯Yes	◯No
Asthma	◯Yes	◯No	Heart Bypass	◯Yes	◯No	Shingles	◯Yes	◯No
Blood Disease (eg. Hemophilia	◯Yes	◯No	Heart Pacemaker	◯Yes	◯No	Sinus Trouble	◯Yes	◯No
Sickle Cell)			Hepatitis A, B, or C	◯Yes	◯No	Shingles	◯Yes	◯No
Cancer	◯Yes	◯No	Herpes	◯Yes	◯No	TMD/Pain in Jaw Joint	◯Yes	◯No
Chemotherapy	◯Yes	◯No	High Blood Pressure	◯Yes	◯No	Tuberculosis (Active)	◯Yes	◯No
Congenital Heart Defect	◯Yes	◯No	Hypoglycemia	◯Yes	◯No	Ulcers	◯Yes	◯No
Depression	◯Yes	◯No	Kidney Problems	◯Yes	◯No	Have you ever had a serious illness not		
Diabetes	◯Yes	◯No	Dialysis	◯Yes	◯No	listed above?	◯Yes	◯No

List Medications/Comments: _____

_____

_____

_____

To the best of my of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes to my medical status

Signature of Patient, Parent, or Guardian: X_____ Date: _____

Signature update: X_____ Date: _____

Signature update: X_____ Date: _____