PATIENT HEALTH HISTORY INFORMATION

Date: | Patient Name (Last, First, MI): | Birth Date (MM/DD/YYYY)

ALLERGIES - Select all that apply:

- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Erythromycin Allergy
- ☐ Hay Fever
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other Allergy:

MEDICATIONS - Please list any medications you are currently taking including vitamins and dietary supplements

☐ Please check this box if your physician or previous dentist recommended you take antibiotics prior to your dental treatment.

Medical Conditions - Please check box if you have had any of the following:

17.0

- ☐ Angina
- ☐ Artifical Heart Valve
- ☐ Congenital Heart Defect
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Heart Attack - If so when?
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Other Heart Problems
- ☐ Stents
- ☐ Stroke If so, when?

- ☐ Acid Reflux
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Ulcers (stomach)

- ☐ Aspergers
- ☐ Autism
- ☐ Epilepsy / Seizure
- ☐ Intellectual Disability
- ☐ Nervous Disorder

Hepatitis ☐ A ☐ B ☐ C

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Kidney Disease

- ☐ Cancer: List type
- ☐ Chemotherapy - If so, when?
- ☐ Radiation - If so, when?

- ☐ Anemia
- ☐ Blood Disorders
- ☐ Leukemia
- ☐ Hemophilia

- ☐ Asthma
- ☐ Use Inhaler
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Mouth Breathing
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring at night
- ☐ Tuberculosis

- ☐ AIDS
- ☐ Herpes
- ☐ HIV Positive
- ☐ HPV
- ☐ Sexually Trans Disease

- ☐ Detached Retina
- ☐ Dizzy Spells/Fainting
- ☐ Glaucoma
- ☐ Nursing
- ☐ Pregnant

Due Date

- ☐ Tumors

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Cerebral Palsy
- ☐ Osteoporosis
- ☐ Rheumatism

- ☐ Diabetes
- ☐ Thyroid Disease

List any other condition you may have

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability, and that any questions that I had have been answered to my satisfaction. 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.

Patient or Legal Guardian Name:

Relationship to Patient:

By signing this form, I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Signature

Date (MM/DD/YYYY)