

HEALTH HISTORY

Patient Name _____ Birthdate _____

Many medical situations can affect or be affected by dental procedures. Please complete the questionnaire carefully. Your records will be kept confidential.

What prompted you to seek dental care at this time? _____

When was your last dental examination? _____

PLEASE CIRCLE

YES NO Are you worried about receiving dental treatment?

YES NO Have you ever had any previous bad dental experiences?

YES NO Do your gums bleed when brushing or flossing your teeth?

YES NO Are you currently under medical treatment?

If yes, please explain _____

YES NO Are you taking prescription drugs or medicine?

If yes, please list _____

YES NO Do you have medical conditions which would require pre-medication for dental treatment? If yes, please explain _____

YES NO Are you allergic to any drugs of medicine? (Penicillin, Antibiotics, Codeine, Aspirin, and Novocain) if yes, please list _____

YES NO Any other allergies? If yes, please list _____

YES NO Have you ever had any excessive bleeding requiring special treatment?

If yes, please explain _____

YES NO Are you currently pregnant?

YES NO Are you taking Birth Control Pills?

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

Heart Trouble

Heart Murmur

Congenital Heart Disease

Anemia

Hepatitis

Arthritis

High Blood Pressure

Rheumatic

HIV, AIDS

Jaundice

Stroke

Fever

Psychiatric Treatment

Epilepsy

Asthma

Kidney Disease

Artificial Joints

Diabetes

Sinus Trouble

Hospitalization

Artificial Valves

Tuberculosis

Radiation Treatment

Congenital

Implants

Operations

Blood Transfusion

Heart Disease

Mitral Valve Prolapse Cancer or Tumor Breathing Problems

Excessive Weight Gain or Loss Pacemaker

PLEASE EXPLAIN BELOW OTHER HEALTH CONDITIONS WE SHOULD KNOW:

The information given above is accurate to the best of my knowledge.

Patient (or Guardian) Signature _____ Date _____