Health History

Name: _____ Physician Name: _____

Physician Phone #: ( )_____ Pharmacy Name & Number:_____

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

Mitral Valve Prolapse_____ Rheumatic Fever_____
Heart Murmur_____ Artificial Joints _____
Artificial Heart Valve_____ Radiation_____ Region_____

Anemia	_____	Low Blood Pressure	_____
Arthritis	_____	Lung Disease	_____
Blood Disease	_____	Kidney Disease	_____
Taking Blood Thinners	_____	HIV/Aids	_____
Cancer	_____	Latex Reaction	_____
Chemotherapy	_____	Local Anesthetic Reaction	_____
Convulsions	_____	Nervous Disorder	_____
Diabetes	_____	Pacemaker	_____
Epilepsy/Seizure	_____	Pregnant _____	Due Date: _____
Excessive Bleeding	_____	Taking Oral Contraceptives?	_____
Fainting	_____	Respiratory Problems	_____
Heart Attack	_____	Stroke	_____
Heart Disease	_____	Tumors	_____
Hepatitis	_____	Thyroid Problems	_____
High Blood Pressure	_____	Osteoporosis	_____
		Taking Meds for Low Bone Density/Osteoporosis	_____

Have you ever had any complications following dental treatment: Yes/No If yes, explain?

_____

Do you or have you ever had any disease, condition, or problem not listed:

_____

Have you ever had to use an antibiotic for premedication before dental treatment? Yes/No If yes, explain:

_____

Have you been ill or needed emergency care recently? Yes/No If yes, explain:

_____

List any/all medications prescribed/over the counter you are taking:

_____

_____

List any medications you are allergic to:_____

Do you use tobacco products/how often?_____

To the best of my knowledge this information is true and correct:
Signature: _____ **Date:** ____/_____/_____