Health History

Name _____ Date _____

Please check all that apply:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Blisters on lips/mouth
- ❑ Tobacco use
  Type _____
- ❑ Jaw/Face Pain
- ❑ Periodontal Treatment
- ❑ Dry Mouth
- ❑ Mouth Blisters/Ulcers
- ❑ Orthodontia/braces
- ❑ When _____
- ❑ Broken Teeth

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Defect
- ❑ Cortisone Treatments
- ❑ Cough, Persistent/Bloody
- ❑ Diabetes
- ❑ Defibulator
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis ABCDEF
- ❑ High Blood Pressure
- ❑ HIV Positive/AIDS
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stomach Problems
- ❑ S.T.D's
- ❑ Stent-Where _____
- ❑ Stroke-When _____
- ❑ Swollen Neck Glands
- ❑ Thyroid Condition
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor/Growth on head/neck
- ❑ Ulcer
- ❑ Vertigo/Dizzy
- ❑ Women: Are you pregnant? Yes / No
- ❑ Any Condition not listed: _____

Medication

List all medications that you are currently taking:

_____

_____

_____

_____

Allergies

- ❑ Amoxicillin
- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other,please specify: _____

Name of Your Family Doctor _____ Phone _____

Address _____ Last visit date _____

Have you had complications with dental work in the past? _____

Have you had complications with anesthesia in the past? _____

Emergency Contact Information

In the event of an emergency, whom should we contact? Name _____

Phone Number _____ Relationship _____

I certify that I have read the contents of this form and have filled it out to the best of my knowledge:

Signature of Responsible Party _____ Date _____