Health History

Name:	Birth Date:

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

- ☐ Acid Reflux
- ☐ AIDS / HIV Positive
- ☐ Allergies
  _____
  _____
  _____
- ☐ Anemia
- ☐ Anxiety / Nervousness
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Artificial Heart Valve
- ☐ Colon cancer
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Breast Cancer
- ☐ Chemo Therapy
- ☐ Chronic Cough
- ☐ Codeine Allergy
- ☐ Cold Sores / Fever Blisters
- ☐ Cortisone
- ☐ Dizziness
- ☐ Epilepsy / Seizure
- ☐ Excessive Bleeding
- ☐ Emphysema
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis – A (Infectious) B (Serum) C (Venereal Disease)
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Hyperlipidemia
- ☐ Hyper- Thyroid
- ☐ Hypo- Thyroid
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Physiological / Psychiatric Disorders
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Special Food Regimen
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Venereal Disease

OTHER:
☐ _____
☐ _____

- Have you been admitted to a hospital or needed emergency care during the **past two years**? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you taken any prescription or recreational drugs during the past year? ☐ Yes ☐ No
  If yes, please list all medications you are currently taking or have taken within the past year: _____
  _____
- Have you taken prescription medication for weight loss? ☐ Yes ☐ No
  If yes, have you taken any of the following?
  - Fen-Phen (Fenfluramine-Phenpermine)? ☐ Yes ☐ No
  - Fosomax (Bisphosphonates)? ☐ Yes ☐ No
  - Pondimen (Fenfluramine)? ☐ Yes ☐ No
  - Redux (Dexfenfluramine)? ☐ Yes ☐ No
- If yes to any of the above, have you had a medical examination for heart complications? ☐ Yes ☐ No
- Do you use two or more pillows while sleeping? ☐ Yes ☐ No

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, Due Date:_____
Are you nursing? ☐ Yes ☐ No
Are you taking Birth Control Pills? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Our office is **HIPAA** compliant and committed to meeting or exceeding the standards of HIPAA, OSHA, CDC and the ADA. _____
Patient Initials

I have received the **dental materials facts** sheet. _____
Patient Initials