Health History

Name________________________ Physicians Name______________________Date of Last Visit______________

Last Visit to Dentist_______________Name___________________________Last Xrays______________________

Any Problems or Concerns____

Do you have any Allergies? Yes / No If Yes, Describe:____

(Women) Are you Pregnant?__________ Are you Nursing?__________ Taking birth control pills?__________

Serious Illness, Operations or Hospitalizations?____

Do you require Pre-Medication prior to Dental Treatment? YES / NO For?________________________
Duration?________ Which Antibiotic?_________________________

Please Check all Past and Present health conditions that apply:

o ADHD/ Autism explain:________________
o Arthritis
o Artificial Heart Valves
o Artificial Joints
o Asthma
o Back Problems
o Blood Disease
o Bone Density Medication
o Bruise easily
o Cancer - Type:___________________Year:_________
o Chemical Dependency (Rx or Recreational)
o Chemotherapy
o Chest Pain, angina
o Chronic Fatigue / night sweats
o Circulatory Problems
o Diabetes - Most Recent A1C:__________
o Emphysema / Difficulty breathing
o Epilepsy
o Eye disease / Glaucoma
o Fainting
o Headaches
o Heart Attacks: Dates_____________________________
o Heart Murmur
o Hepatitis A, B, or C ____________________
o High Blood Pressure
o High Cholesterol
o HIV/AIDS
o Jaw Pain
o Kidney Disease
o Liver Disease
o Low Blood Pressure
o Mitral Valve Prolapse
o Pacemaker
o Radiation Treatment
o Respiratory Disease
o Scarlet/Rheumatic Fever
o Shortness of Breath
o Sleep Apnea -- CPAP: Yes / No
o Snoring
o Stroke year:____________________
o Swelling of Feet or Ankles
o Thyroid Problems
o Tobacco / Smokeless / Vape
o Tuberculosis
o Vertigo
o Other:____

List of Medications you take regularly: (If you have a list with you we will gladly make a copy and attach)

________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________

To the best of my Knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ __________________________

Signature of Patient, Parent, Guardian or Personal Representative Date