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(PLEASE PRINT)

HEALTH HISTORY

PERSONAL PHYSICIAN _____ _____
NAME STREET

_____
CITY STATE ZIP

Yes	No	
☐	☐	HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS?
		DATE / REASON _____
☐	☐	ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN?
		REASON _____ PHYSICIANS NAME _____
☐	☐	HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY MEDICATION, FOOD OR METAL?
		PLEASE LIST _____
☐	☐	DO YOU BLEED EXCESSIVELY UPON INJURY?
☐	☐	DO YOU SMOKE OR USE SMOKELESS TOBACCO? IF YES, FREQUENCY _____
☐	☐	(WOMEN) ARE YOU PREGNANT?
☐	☐	ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR HERBAL "NATURAL" DRUGS? PLEASE LIST

MEDICATION	DOSAGE	REASON

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

☐ AIDS	☐ DIABETES	☐ HEPATITIS	☐ RHEUMATIC FEVER
☐ ARTHRITIS	☐ EPILEPSY	☐ HIGH BLOOD PRESSURE	☐ SEXUALLY TRANSMITTED DISEASE
☐ ARTIFICIAL JOINT	☐ HEART MURMUR	☐ JAUNDICE	☐ STROKE
☐ ASTHMA	☐ HEART PROBLEMS	☐ KIDNEY PROBLEMS	☐ TUBERCULOSIS
☐ CANCER	_____	☐ LOW BLOOD PRESSURE	☐ (OTHER) _____
	_____		

PERSON TO BE CONTACTED IN AN EMERGENCY (OTHER THAN HOUSEHOLD MEMBER)

_____ _____ _____
NAME ADDRESS PHONE

I WILL NOTIFY THE DENTIST OF ANY CHANGE IN MY HEALTH HISTORY PRIOR TO MY DENTAL TREATMENT. I CERTIFY THE ABOVE INFORMATION TO BE CORRECT.

X _____ _____
SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR) DATE

UPDATED

HEALTH HISTORY