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HEALTH HISTORY

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

Dental Health History

Are you apprehensive about dental treatment? * ◯ Yes ◯ No

Is there anything about the appearance of your teeth that you would like to change? * ◯ Yes ◯ No

Have you ever experienced complications following dental treatment? * ◯ Yes ◯ No

Medical Health History

Physician Name: * _____

Do you have any allergies to medications or latex products? * ◯ Yes ◯ No

If yes, please list any allergies:

_____

_____

Do you use tobacco products? * ◯ Yes ◯ No

Do you have a history of Fosamax Treatment (or other osteoporosis medication)? * ◯ Yes ◯ No

Do you have or have you ever had any of the following conditions:

☐ Acid Reflux	☐ Artificial Joints	☐ Bleeding Disorder	☐ Cancer
☐ Diabetes	☐ Epilepsy or Seizures	☐ HIV/AIDS	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ Mitral ValveProlapse	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic HeartFever	☐ Sinus Problems	☐ Sleep Apnea	☐ Snoring
☐ Stroke	☐ Thyroid Disorder	☐ Tuberculosis	

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Do you have any other illness, condition, or problem not listed above? * ◯ Yes ◯ No

If yes, please describe briefly:

_____

_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Authorized Representative:

Signature _____ **Date** _____

Response Date: