Health History

Physician Name: _______________________________ Phone #:_______________

Date of last visit: ____

PLEASE ANSWER WITH AN "X" IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

_____HEART PROBLEMS
_____MITRAL VALVE PROLAPSE
_____HIGH BLOOD PRESSURE
_____LOW BLOOD PRESSURE
_____BLOOD DISORDERS
_____CIRCULATORY PROBLEMS
_____CANCER
_____RADIATION TREATMENT
_____ANEMIA
_____NERVOUS PROBLEMS
_____MUMPS
_____DO YOU SMOKE
_____TONSILITIS
_____PREGNANT NOW
HOW MANY MONTHS___
_____RHEUMATIC FEVER
_____SCARLET FEVER
_____EPILEPSY
_____DIABETES
_____ASTHMA
_____FAINTING OR DIZZY SPELLS
_____MONONUCLEOSIS
_____ARTHRITIS
_____HEPATITIS
_____SINUS

_____STROKE
_____THIRSTY OR DRY MOUTH
_____ULCER
_____HIP, KNEE, JOINT, OR ANY ARTIFICIAL REPLACEMENTS
_____THYROID DYSFUNCTION
_____HYPOTHYROID, HYPER THYROID
_____TUBERCULOSIS
_____PSYCHIATRIC CARE
_____HAY FEVER, ALLERGIES
_____COLD SORES
_____PAIN IN EAR REGION
_____VENEREAL DISEASE
_____AIDS
_____HIV POSITIVE

ALLERGIES OR REACTIONS TO:

_____PENICILLIN
_____AMOXICILLIN
_____ERYTHROMYCIN
_____TETRACYCLINE
_____CODEINE
_____TRANQUILIZERS
_____OTHERS (NAME_______________)

Please describe any current medical treatment. List all drugs or medications that you are taking and any pending operation or condition that might effect your dental treatment.

____
____
____

Patient
Signature: __________________________________ Date:____________________
Doctor
Signature: __________________________________ Date:____________________