Health Information

Patient Name:

Have you experienced any of the following?

Y	N				
☐	☐	Angina/Chest Pain	☐ ☐	Frequent Cough	☐ ☐ Pain in Jaw Joints
☐	☐	Breathing Problems	☐ ☐	Frequent Diarrhea	☐ ☐ Recent Weight Loss
☐	☐	Bruise Easily	☐ ☐	Frequent Urination	☐ ☐ Sinus Problems
☐	☐	Difficulty Swallowing	☐ ☐	Hives or Rash	☐ ☐ Swollen Joints
☐	☐	Excessive Thirst	☐ ☐	Jaundice	
☐	☐	Fainting or Dizziness	☐ ☐	Nervousness	

Are you allergic to:

Y	N						
☐	☐	Penicillin	☐	☐	Local anesthetic (Novocain/Xylocaine)	☐ ☐	Vicodin
☐	☐	Latex	☐	☐	Nitrous Oxide	☐ ☐	Percodan
☐	☐	Aspirin	☐	☐	Valium	☐ ☐	Food
☐	☐	Codeine	☐	☐	Erythromycin	☐ ☐	Metal
			☐	☐	Tetracycline	☐ ☐	Other: _____

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

Y	N						
☐	☐	AIDS (HIV+)	☐ ☐	Glaucoma/Eye Disease	☐ ☐	Radiation Treatment
☐	☐	Allergies (Pollen Dust)	☐ ☐	Heart Attack/Failure	☐ ☐	Scarlet/Rheumatic Fever
☐	☐	Alzheimer's Disease	☐ ☐	Heart Murmur/Irregularity	☐ ☐	Sickle Cell Disease
☐	☐	Anemia	☐ ☐	Hepatitis A / B / C	☐ ☐	Skin Disease
☐	☐	Arthritis/Gout/Rheumatism	☐ ☐	Herpes	☐ ☐	Stroke
☐	☐	Artificial Heart Valve	☐ ☐	High Blood Pressure	☐ ☐	Stomach Problems/ IBS
☐	☐	Artificial Joints	☐ ☐	Hypoglycemia	☐ ☐	Intestinal Problems
☐	☐	Asthma	☐ ☐	Kidney Problems	☐ ☐	Thyroid Disease
☐	☐	Blood Disease	☐ ☐	Leukemia	☐ ☐	Transplant
☐	☐	Cancer/Chemotherapy	☐ ☐	Liver Disease	☐ ☐	Tuberculosis
☐	☐	Cold Sores	☐ ☐	Low Blood Pressure	☐ ☐	Tumors or Growths
☐	☐	Congenital Heart Disorder	☐ ☐	Lung Disease	☐ ☐	Ulcers
☐	☐	Cortisone Medicine	☐ ☐	Migraines	☐ ☐	Other
☐	☐	Diabetes	☐ ☐	Mitro Valve Prolapse		
☐	☐	Drug/Alcohol Addiction	☐ ☐	Orthodontics		
☐	☐	Dry Mouth	☐ ☐	Osteoporosis		
☐	☐	Emphysema/Lung Disease	☐ ☐	Periodontal Treatment		
☐	☐	Epilepsy or Seizures	☐ ☐	Psychiatric Care		

Do you need to Pre-Medicate for your dental appointment? ☐ Yes ☐ No

Have you had any previous dental complications? ☐ Yes ☐ No If yes, please explain_____

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, please explain_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain_____

Women: (please check) ☐ pregnant / trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Have you taken any supplements, tobacco, and alcohol or had significant weight loss in the last 3 months?_____

List all current medications:_____

_____

_____

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

_____ Date:_____
Signature of patient, parent or guardian

Doctor: _____ Date:_____ Patient BP:_____