Health History

CIRCLE

1. Are you having pain or discomfort at this time? .... YES NO
2. Do you feel very nervous about having dental treatment? .... YES NO
3. Have you ever had a bad experience in the dental office? .... YES NO
4. Have you been a patient in the hospital during the past two years? .... YES NO
5. Have you been under the care of a medical doctor during the past two years? .... YES NO
   Physician's Name ____________________
   Address ____________________ Phone # ____________
6. Have you taken any medicine or drugs during the past two years? .... YES NO
   Are you now taking any medication, drugs or pills? .... YES NO
   If yes, please list ____________________
7. Are you allergic or have you reacted adversely to any of the following? .... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic	Nickel
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)	Latex
Codeine	Tetracycline	Penicillin	Sleeping Pills	
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)	

8. Are you aware of being allergic to any other medications or substance? .... YES NO
   If yes, please list ____________________

Date		Date		Date	
___	Heart Failure	___	Emphysema	___	A.I.D.S.
___	Heart Disease or Attack	___	Cough	___	Hepatitis A (infectious)
___	Angina Pectoris	___	Tuberculosis (TB)	___	Hepatitis B (serum)
___	High Blood Pressure	___	Asthma	___	Liver Disease
___	Heart Murmur	___	Hay Fever	___	Yellow Jaundice
___	Rheumatic Fever	___	Sinus Trouble	___	Blood Transfusion
___	Congenital Heart Lesions	___	Allergies or Hives	___	Drug Addiction
___	Scarlet Fever	___	Diabetes	___	Hemophilia
___	Artificial Heart Valve	___	Thyroid Disease	___	Venereal Disease
___	Heart Pacemaker	___	X-Ray or Cobalt Treatment	___	Cold Sores
___	Heart Surgery	___	Chemotherapy	___	Fever Blisters
___	Artificial Joints (Hip, Knee)	___	Arthritis	___	Epilepsy or Seizures
___	Anemia	___	Rheumatism	___	Fainting or Dizzy Spells
___	Stroke	___	Cortisone Medicine	___	Nervousness
___	Kidney Trouble	___	Glaucoma	___	Psychiatric Treatment
___	Ulcers	___	Pain in Jaw Joints	___	Sickle Cell Disease
___	Cosmetic Surgery	___	Mitral Valve Prolapse	___	Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... YES NO
11. Do your ankles swell during the day? .... YES NO
12. Do you use more than 2 pillows to sleep? .... YES NO
13. Have you lost or gained more than 10 pounds in the past year? .... YES NO
14. Do you ever wake up from sleep short of breath? .... YES NO
15. Are you on a special diet? .... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? .... YES NO
17. Do you have any disease, condition, or problem not listed? .... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO , If yes, what month? ____________

Are you taking birth control pills? ☐ YES ☐ NO

ABOVE INFORMATION IS TRUE.

Patient Signature ____________________ Date ____________

Responsible Party ____________________ Relationship to Patient ____________

Update: (for office use only):