HEALTH HISTORY

NAME ______________________________ DATE OF BIRTH _________________ DATE__________________

Please answer ALL questions below

1. Are you in good health? Y N
2. Has there been any change in your general health in the last year? Y N
3. Date of last physical exam________________________
4. Are you under the care of a physician for a particular problem? Y N
5. Have you ever had any serious illnesses operations, or hospitalizations? Y N
   If so, describe___________________________________
6. Height_______________ Weight__________________
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever? Y N
   - B. Rheumatic Heart Disease? Y N
   - C. Congenital Heart Disease? Y N
   - D. Cardiovascular Disease (Heart Attack, Heart Murmur, Heart Trouble, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N
   - E. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, TB, Shortness of breath, Chest pain, Severe Coughing)? Y N
   - F. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
   - G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Y N
   - H. Do you bruise easily? Y N
   - I. Liver Disease? (Jaundice, Hepatitis) Y N
   - J. Kidney Disease? Y N
   - K. Diabetes? Y N
   - L. Thyroid Disease? (Goiter) Y N
   - M. Arthritis? Y N
   - N. Stomach Ulcers or Colitis? Y N
   - O. Glaucoma? Y N
   - P. Implants placed anywhere in body? (Heart Valve, Pacemaker, Hip, Knee) Y N
   - Q. Radiation (X-ray) treatment for cancer? Y N
   - R. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
   - S. Sinus of nasal problems? Y N
   - T. Any disease, drug or transplant operation that depresses your immune system? Y N
8. ARE YOU USING ANY OF THE FOLLOWING?
   - A. Antibiotics? Y N
   - B. Anticoagulants? (Blood Thinners) Y N
   - C. Aspirin or drugs such as Motrin, Aleve or Ibuprofen? Y N
   - D. High Blood Pressure Medications? Y N
   - E. Steroids? (Cortisone, etc.)? Y N
   - F. Tranquilizers? Y N
   - G. Insulin or Oral Anti-diabetic drugs? Y N
   - H. Digitalis, Inderal, Nitroglycerin, or other heart drug? Y N
   - I. Please list **any and all medications** taken, including over-the-counter medications, herbal or holistic remedies, vitamins or minerals:__________________
     ____
     ____
   - J. ARE YOU ALLERGIC TO OR HAVE YOU AN ADVERSE REACTION TO:
     - A. Local Anesthesia? (Novocain, etc.) Y N
     - B. Penicillin or other antibiotics? Y N
     - C. Sedatives, Barbiturates? Y N
     - D. Aspirin or Ibuprofen? Y N
     - E. Codeine or other pain killers? Y N
     - F. Latex or Rubber Products? Y N
     - G. Other allergies or reactions? Y N
       Please list____
10. Do you smoke or chew tobacco? Y N
    How much per day?_______________
11. Is there any past history of alcohol or chemical dependency or emotional disorder that may effect the care we provide you? Y N
12. Have you had any serious problems associated with any previous dental treatment? Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should be aware of? Y N
15. Do you wish to talk with the doctor privately about anything? Y N
16. *FOR WOMEN ONLY:
    - A. Are pregnant or is there a chance you may be pregnant? Y N
    - B. Are you nursing? Y N
    - ** If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of your oral contraceptives. Please use appropriate precautions.

Family Physician ____

Phone Number ____

Have you seen a specialist for any health conditions listed? Y N

If so, please give names ____________________________________

Emergency Contact__________________________ Relationship________________ Phone Number __________________
(Someone not living with you, please)

I understand the importance of a truthful health history to assist the doctor in providing the best care possible, thus the information given above is true and correct to the best of my knowledge. I have had the opportunity to discuss my health history with the doctor.

Signature____________________________________ Date______________________ Doctor's Initials________________