Health History

Last Name	First Name	MI	Date

Address	Apt. No.	Home Phone
City, State	Zip Code	Work Phone
Reason for Your Visit		Cell Phone

Male	Female	Married	Single	Child	Other	Date of Last Dental Visit

Previous Dentist's Name	City, State	Did you bring your records?

Check Those That Apply to You

	AIDS		Emphysema		Latex Allergy or Sensitivity		Tobacco Use
	Allergies (list)		Epilepsy		Liver Disease		Tuberculosis
	Anemia		Excessive Bleeding		Mental Disorder		Tumors
	Arthritis		Fainting		Mitral Valve Prolapse		Ulcers
	Artificial Joints		Glaucoma		Nervous Disorder		Venereal Disease
	Artificial Heart Valve		Growths		Pacemaker		
	Asthma		Hay Fever		Psychiatric/Psychological Care	**List Medication Allergies**	
	Blood Disease		HIV Positive		Pregnancy (due date:		
	Bruise Easily		Head Injuries		Radiation Treatment		
	Cancer		Heart Problems (attack, disease, surgery)		Respiratory Problems		
	Cold Sores/Fever Blisters		Heart Murmur		Rheumatic Fever		
	Contact Lenses		Hemophilia		Rheumatism		
	Cortisone Medication		Hepatitis		Sinus Problems		
	Diabetes		High Blood Pressure		Stomach Problems		
	Diet (Restricted)		Jaundice		Stroke		
	Dizziness		Kidney Disease		Thyroid Problems		

General Health Questions

Have you experienced problems after dental treatment in the past? If so, explain.
Do you have any chronic dental or gum problems?
Are you experiencing oral pain? If so, explain.
Are you taking medications regularly? If so, list them here.
Have you been admitted to a hospital or emergency room in the past 24 months?
Are you currently under a physician's care? If so, please give your doctor's name and phone number.

By signing below, you verify that all of the information provided in this form is accurate and true to the best of your knowledge. You also agree to inform us if any of this information changes in the future.

Signature ______________________ Date ____________