Health Information

Patient Name: ______________________ Date of Birth: ______________________
Physicians Name: ______________________ Phone: ______________________
Address: ______________________
When was your last physical? ______________________
Have you had a serious illness or injury in the past two years? △ Yes △ No
Please explain: ______________________

List any medications you are currently taking and their purpose.

______________________ ______________________
______________________ ______________________
______________________ ______________________

Are you allergic or have you reacted adversely to any of the following items? **Please check those that apply**.

△ Anesthetic	△ Erythromycin	△ Latex	△ Sulfa
△ Aspirin	△ Eucalyptus	△ Nickel	△ Tetracycline
△ Codeine	△ Fluoride	△ Nitrous Oxide	△ Valium
△ Darvon	△ Ibuprofen	△ Penicillin	

Are you aware of being allergic to any other medications or substances? △ Yes △ No
Please explain: ______________________

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

△ AIDS	△ Depression	△ Heart Surgery	△ Nervous Disorders
△ Anemia	△ Diabetes	△ Hemophilia	△ Pacemaker
△ Angina	△ Dizziness	△ Hepatitis A	△ Psychiatric Treatment
△ Anorexia / Bulimia	△ Emphysema	△ Hepatitis B	△ Radiation Treatment
△ Arthritis	△ Epilepsy	△ Hepatitis C	△ Rheumatic Fever
△ Artificial Heart Valve	△ Fainting	△ High Blood Pressure	△ Seizures
△ Artificial Joints	△ Hay Fever	△ HIV	△ Sinus Problems
△ Asthma	△ Head Injuries	△ Jaw Injury	△ Stroke
△ Cancer	△ Headaches	△ Jaw Joint Pain	△ Thyroid Disease
△ Cold Sores	△ Heart Attack	△ Kidney Disease	△ Tuberculosis (TB)
△ Congenital Heart Disease	△ Heart Disease	△ Liver Disease	△ Tumors
△ Cosmetic Surgery	△ Heart Murmur	△ Mitral Valve Prolapse	△ Ulcers

Have you ever been dependent on drugs or alcohol? △ Yes △ No
Do you smoke or use other forms of tobacco? △ Yes △ No
Are you on a salt restricted diet? △ Yes △ No
Has your physician ever recommended taking antibiotics prior to dental appointments? △ Yes △ No
Have you ever had any adverse reactions to dental treatment? △ Yes △ No
Please explain: ______________________
Do you have any health conditions that need further clarification? △ Yes △ No
Please explain: ______________________
____
____

For Women Only:
Are you pregnant? △ Yes △ No
Are you taking birth control pills? △ Yes △ No

To the best of my knowledge, all of the proceeding information provided is true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

______________________ Date: ______________________
Signature of patient, parent or legal guardian