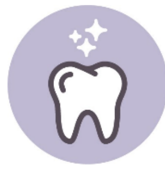

Patient Health History Information

Date: ________________Patient Name: ____ Birth Date: _______________ Age: _____

DENTAL HISTORY

1. What is the reason for your dental visit today? ____
2. When was your last dental visit? ___________________What treatment was performed? _________________________
3. When were the last dental X-rays taken? _____________ Was all treatment completed? __________________________
4. Have you ever had prolonged bleeding after an extraction? Yes___ No___

   If yes please explain____
5. Do your gums bleed easily? Yes___ No___ Are your teeth sensitive to hot or cold? Yes___ No___

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? Yes___ No___ If yes, please specify: ________________

   Dr. Name_______________________________________ Doctor's Phone: ______________________
2. Are you **allergic** to Penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? ____
3. Are you **taking any medication** at this time, including birth control? Yes___ No__

   If yes, please specify: ____
4. (**WOMAN**) Are you pregnant at this time? Yes___ No____
5. Do you have, or have you had, any of the following?

   Please check Yes or No

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Artificial Heart valve	Yes	No	Heart problems	Yes	No
Aids/HIV+	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Blood pressure	Yes	No
Angina	Yes	No	jaundice	Yes	No
Arthritis	Yes	No	joint prosthesis	Yes	No
Asthma	Yes	No	kidney Disease	Yes	No
Bleeding Problems	Yes	No	Liver Problems	Yes	No
Cancer	Yes	No	Low Blood Pressure	Yes	No
Chem./Rad Thrapy	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Dizzy Spells	Yes	No	Psychiatric Care	Yes	No
Drug Addiction	Yes	No	Rheuamtic Fever	Yes	No
Emphysema	Yes	No	Sinus Trouble	Yes	No
epilepsy	Yes	No	Smoking Tobaco	Yes	No
Fainting	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Thryroid Problems	Yes	No
Heart Attack	Yes	No	TMD or TMJ	Yes	No
Heart Surgery	Yes	No	Tuberculosis	Yes	No

6. **Are there other conditions of which we should be aware? Yes___ No____ If yes, please specify:**
____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. I further certify that I consent to the performing of X-rays and oral Examination.

Patient/Guardian Signature: _______________________ Doctor's Signature: ________________________Date: ___________

Patient/Guardian Signature: _______________________ Doctor's Signature: ________________________Date: ___________