Health History

Patient Name:_____Date of Birth:_____

Place a mark on "yes" or "no":

AIDS/HIV	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tumor or growth on				
ANEMIA	❑Yes	❑No	Heart Problems	❑Yes	❑No	Head/Neck	❑Yes	❑No		
Arthritis, Rheumatism	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Ulcer	❑Yes	❑No		
Artificial Heart Valves	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Sleep Apnea	❑Yes	❑No		
Artificial Joints	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Pregnancy	❑Yes	❑No		
Asthma	❑Yes	❑No	Liver Disease	❑Yes	❑No	Due Date? _____				
Bleeding abnormally,	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Nursing Mother	❑Yes	❑No		
with extractions or surgery			Nervous Problems	❑Yes	❑No	Discomfort with				
Blood Disease	❑Yes	❑No	Pacemaker	❑Yes	❑No	Head or Neck	❑Yes	❑No		
Cancer	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Jaw Pain	❑Yes	❑No		
Chemotherapy	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Jaw Popping	❑Yes	❑No		
Circulatory Problems	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Limited Opening	❑Yes	❑No		
Cortisone Treatments	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Congested Ears	❑Yes	❑No		
Cough, persistent	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Ringing Ears	❑Yes	❑No		
Diabetes	❑Yes	❑No	Stroke	❑Yes	❑No	Dizziness	❑Yes	❑No		
Epilepsy	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Posture Problems	❑Yes	❑No		
Fainting or Dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Clenching	❑Yes	❑No		
Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No	Grinding	❑Yes	❑No		
Heart Lesions	❑Yes	❑No	Tonsillitis	❑Yes	❑No	Facial Pain	❑Yes	❑No		
Weight Loss/Gain	❑Yes	❑No	Tuberculosis	❑Yes	❑No	Bell's Palsy	❑Yes	❑No		

List any medications you are currently taking; please include any blood thinning medications or aspirin:

_____

_____

_____

Are you allergic to any medications or substances?

_____

_____

Have you taken or currently taking medications for osteoporosis, known as biphosphonates? For example: Fosamax, Actonel, or Boniva? ❑Yes ❑No

Do you take antacids? ❑Yes ❑No

Circle if you have had: Bite Related Treatment Orthodontics - Bite Adjusted - TMJ Joint Surgery

Circle if you have seen any of the following health care professionals:
ENT - Neurologist - Chiropractor - Massage Therapist

Do you snore, use a CPAP, or have had a sleep study?
❑Yes ❑No

Have you ever had radiation to the head and/or neck?
❑Yes ❑No

Do you use tobacco products? ❑Yes ❑No

Do you consume grapefruits, grapefruit juice, or grapefruit extract? ❑Yes ❑No

Has a physician ever told you to take an antibiotic pre-medication prior to dental treatment? ❑Yes ❑No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the dentist at my next appointment without fail. I consent to whatever dental procedures and anesthetics are necessary for treatment.

Date: _____ Signature of Patient/Parent/Guardian: _____