HEALTH HISTORY

Are you under the care of a medical doctor at present? ☐ YES ☐ NO

Primary Physician's Name _____ Phone _____ Fax _____

Specialist's Name _____ Phone _____ Fax _____

Specialist's Name _____ Phone _____ Fax _____

Specialist's Name _____ Phone _____ Fax _____

Are you taking any medications, drugs, and/or supplements? ☐ YES ☐ NO If yes, please list:
☐ Check box if you provided an updated list of your medications today. (We can make a copy)

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

Name_____ Dose _____ Use _____

(continue on back)

Are you allergic to any of the following? ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Clindamycin ☐ Hydrocodone ☐ Keflex ☐ Azithromycin ☐ Dental Anesthetic ☐ Other _____

Are you required to take antibiotics prior to dental procedures? (Such as Amoxicillin, Penicillin, Clindamycin) ☐ YES ☐ NO

Women: are you pregnant? ☐ YES ☐ NO If yes, how many months pregnant are you as of today's date? _____

Do you have, or have you ever had, any of the following?

	YES	NO		YES	NO		YES	NO
Aids/Hiv +	☐	☐	Fainting or Dizziness	☐	☐	Osteoporosis/Penia	☐	☐
Anemia/Sickle Cell	☐	☐	Fibromyalgia	☐	☐	Pacemaker	☐	☐
Artificial Heart Valves	☐	☐	Gastric Reflux	☐	☐	Panic Attacks	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Persistent Cough	☐	☐
Arthritis	☐	☐	Heart Problem	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Heart Surgery	☐	☐	Radiation Therapy	☐	☐
Blood Transfusion (Recent)	☐	☐	Hepatitis A, B, C	☐	☐	Recreational Drug Use	☐	☐
Bruise/Bleed Easily	☐	☐	Irregular Heartbeat	☐	☐	Rheumatic Fever	☐	☐
Cancer/Tumor	☐	☐	Kidney Problems	☐	☐	Sinus Problems	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Sleep Apnea	☐	☐
Chest Pain/Angina	☐	☐	Low Blood Pressure	☐	☐	Snoring	☐	☐
Cold Sores/Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Current Steroid Use	☐	☐	Medical Marijuana	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Metal Allergy	☐	☐	Tobacco Use	☐	☐
Dry Mouth	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis/PPD +	☐	☐
Emphysema/Bronchitis	☐	☐	Nervousness/Anxiety	☐	☐	_____	☐	☐
Epilepsy or Seizures	☐	☐	Organ Transplants	☐	☐	_____	☐	☐

Do you have any condition, disease, or problem not previously listed? _____

_____

To the best of my knowledge, the above information is true and correct.

Patient Name Printed _____

Patient/Guardian Signature _____ Date_____