

Patient Health History

Please circle:

- Y N Are you in pain or discomfort at this time?
- Y N Do you feel very nervous about having dental treatment?
- Y N Have you ever had a bad experience in the dental office?
- Y N Are you happy with the appearance of your smile?
- Y N Have you been a patient in the hospital during the last two (2) years?
If yes, please explain _____
- Y N Have you been under the care of a medical doctor during the last two (2) year?
Physician's Name _____ Phone No. _____
Address _____ City _____ State _____
- Y N Are you now taking any prescribed or non prescription medications, drugs or pills?
If yes, please list _____

Are you allergic or have you reacted adversely to any or the following medications?;

- | | |
|---|----------------------------------|
| Y N Aspirins | Y N Other Antibiotics Penicillin |
| Y N Codeine | Y N Penicillin |
| Y N Darvon | Y N Percodan |
| Y N Demerol | Y N Scopolamine |
| Y N Erthromycin | Y N Sleeping Pills |
| Y N Local Anesthetics
(Novocain or Xylocaine) | (Nembutal or Seconal) |
| Y N Nitrous Oxide | Y N Tetracycline |
| Y N Are you aware of being allergic to any other medications or substances:
If yes, Please list: _____ | Y N Valium |

Please circle yes or no to any of the following you have had or have at the present:

- | | |
|----------------------------------|---|
| Y N Heart Failure | Y N Xray or Colbalt Treatment |
| Y N Heart Disease or Attack | Y N Chemotherapy (Cancer or Leukemia) |
| Y N Angina Pectoris | Y N Arthritis |
| Y N High Blood Pressure | Y N Rheumatism |
| Y N Rheumatic Fever | Y N Cortisone Medication |
| Y N Congenital Heart Lesions | Y N Glaucoma |
| Y N Scarlet Fever | Y N Pain in Jaw Joints |
| Y N Artificial Heart Valve | Y N Abnormal bleeding with previous
extractions or surgery |
| Y N Heart Pacemaker | Y N A.I.D.S. |
| Y N Heart Surgery | Y N Hepatitis A (infectious) |
| Y N Artificial Joints (Hip,Knee) | Y N Hepatitis B (serum) |
| Y N Anemia | Y N Liver Disease |
| Y N Stroke | Y N Yellow Jaundice |
| Y N Kidney Trouble | Y N Blood Transfusion |
| Y N Ulcers | Y N Drug Addiction |
| Y N Cosmetic Surgery | Y N Hemophilia |
| Y N Emphysema | Y N Venereal Disease (Syphilis, Gonorrhea) |
| Y N Cough | Y N Cold Sores |
| Y N Tuberculosis (TB) | Y N Fever Blisters |
| Y N Asthma | Y N Epilepsy or Seizures |
| Y N Hay Fever | Y N Fainting or Dizzy Spells |
| Y N Sinus Trouble | Y N Nervousness |
| Y N Allergies or Hives | Y N Psychiatric Treatment |
| Y N Diabetes | Y N Sickle Cell Disease |
| Y N Thyroid Disease | |
| Y N Bruise Easily | |

- Y N When you walk up stairs do you ever have to stop because of pain in your chest or shortness of breath?
- Y N Do your ankles swell during the day?
- Y N Do you use more than two (2) pillows to sleep?
- Y N Have you lost or gained more than ten (10) pounds in the past year?
- Y N Do you ever wake up short of breath?
- Y N Are you on a special diet?
- Y N Has your medical doctor ever said your have cancer or a tumor?
- Y N Do you have any disease, conditions or problems not previously listed?
If yes. Please list _____
- Y N Do you smoke?
- Y N Do you participate in any activity that would increase the possibility of HIV infection?
- Y N Have you ever had an HIV blood test ?
If yes, what was the date _____ & the results _____

For Women Only:

- Y N Are you pregnant?
If yes, What month _____
- Y N Are you taking birth control pills?

I certify that the above information is true and correct.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____