Health History

Date:_____

Name: _____Birth Date:_____

Are you in good Health… ☐Yes ☐No If No, please explain? _____

Are you being treated by a physician now? ☐Yes ☐No If yes, what for _____

_____

Current Physician name? _____ Phone Number: _____

Please list your medications and/or supplements, and reason for taking._____

_____

_____

Are you allergic to any of the following medications or have you had any unusual reactions?

☐ Local Anesthetics (Novocaine)
☐ Aspirin
☐ Pain Medication
☐ Penicillin / Amoxicillin
☐ Latex Allergy
☐ Metal Allergy
☐ Other: _____

Please check if you have or had any of the following conditions.

☐ Excess Bleeding After Surgery
☐ Blood Disorder
☐ Anemia
☐ HIV/Aids
☐ Tuberculosis
☐ Hepatitis ☐A ☐B ☐C
☐ Diabetes ☐I ☐II
☐ Heart Disease
☐ Stroke
☐ High Blood Pressure
Reading _____
☐ Pace Maker
☐ Use Tobacco
☐ Kidney Disease
☐ Rheumatic Fever
☐ Heart Murmur
☐ Artificial Heart Valve
Or Joint
☐ Asthma
☐ Shortness of Breath
☐ Respiratory Disorder
☐ Thyroid Disease
☐ Glaucoma
☐ Arthritis
☐ Epilepsy
☐ Cancer
☐ Are you taking
Coumadin
☐ Gum Disease
☐ Braces
☐ Clench or Grind Teeth

☐ Other:_____

☐ Surgery in last 5 years. Reason:_____

Are you pregnant? … ☐ Yes ☐ No If yes, what tri-mester? _____

Patient Signature:_____Date:_____

Dr./Hyg. Signature:_____Date:_____

Health history update: _____
Patient's Initial: _____ Date: _____ Dr./Hyg. Initial:_____ Date:_____

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