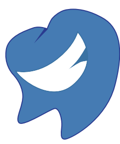

DENTAL HISTORY

Date of Last Dental Treatment: ________________________ Date of Last Dental X-Rays: ________________________

Last Dental Office: ____ Phone: ______________________

Have you ever had any unfavorable reaction from a local anesthetic? ☐ Yes ☐ No If Yes, Please Explain: _______________

____

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No If Yes, Please Explain: _______

____

MEDICAL HISTORY

Your answers are for our records only and will be considered confidential. Sex: _______ Height: _______ Weight: _______

In the following questions circle yes or no, whichever applies:

1. Yes / No Are you in good health?
2. Yes / No Has there been any change in your general health within the past year? Date of last physical exam ________________
3. Yes / No Are you now, or have you been, under the care of a physician during the past two years?
   If so, what is the condition being treated? ____
4. Yes / No Have you ever been hospitalized or had a serious illness? If so, what was the problem?
   ____

Do you have or have you had any of the following diseases or conditions?

CARDIOVASCULAR

Yes / No Rheumatic Fever
Yes / No Congenital Heart Defect
Type: Surgery Date:
Yes / No Angina Pectoris
Frequency:
Yes / No Myocardial Infarction (Heart Attack)
Date:
Yes / No Arrhythmias (Irregular Heart Beat)
Type:
Yes / No Cardiac Murmur
Cause:
Yes / No Congestive Heart Failure
Date:

Yes / No Heart Surgery
Type: Surgery Date:
Yes / No Pacemaker Implanted
Type: Date:
Yes / No Hypertension (High Blood Pressure)
BP: /
Yes / No Hypotension (Low Blood Pressure)
BP: /
Yes / No Stroke (CVA)
Date:
Yes / No Other
Explain:

RESPIRATORY DISEASE

Yes / No Asthma
Severity:
Yes / No Emphysema
Severity:
Yes / No Hay Fever or Sinusitis
Yes / No Bronchitis
Severity:
Yes / No Other
Explain:

ORTHOPEDIC SURGERIES

Yes / No Hip Replacement
Date:
Yes / No Knee Replacement
Date:
Yes / No Shoulder Replacement
Date:
Yes / No Other Joint Replacement
Date:

ENDOCRINE DISORDERS

Yes / No Diabetes
Type:
Yes / No Hyperthyroidism (High Thyroid)
Treatment:
Yes / No Hypothyroidism (Low Thyroid)
Treatment:

HEMATOLOGIC (BLOOD) DISORDERS

Yes / No Anemia
Type:
Yes / No Leukemia
Type:
Yes / No AIDS or HIV Positive

Yes / No Bleeding Tendency - Do you bruise easily or bleed excessively when cut? If yes, explain:

Yes / No Have you ever had a blood transfusion? If yes, explain:

Do you have or have you had any of the following diseases or conditions? [Continued]

PSYCHIATRIC CONDITIONS

Yes / No Have you seen a psychiatrist in the last 3 years? Psychiatrist: ____________________ Phone: ____________________

INFECTIOUS DISEASES

Yes / No Hepatitis
Type: Date:
Yes / No Venereal Disease
Type: Date:
Yes / No Tuberculosis
Type: Date:

Yes / No MRSA
Date:
Yes / No VRE
Date:
Yes / No Other
Date:

RENAL (KIDNEY) DISEASE

Yes / No Have you had a kidney infection within the last 3 years? Type: ____________________ Date: ____________________
Yes / No Have you had kidney surgery? Type: ____________________ Date: ____________________

OTHER DISEASES & DISORDERS

Yes / No Syncope (Fainting)
Frequency:
Yes / No Liver Disease
Type:
Yes / No Cancer
Type: Date:
Yes / No Radiation Therapy
Type: Date:
Yes / No Glaucoma

Yes / No Epilepsy
Treatment:
Yes / No Arthritis
Type:
Yes / No Ulcers
Type:
Yes / No Have you had surgery or xray treatment for a tumor, growth, or other condition?

MEDICATION - ARE YOU TAKING ANY OF THE FOLLOWING?

Yes / No Antibiotics or Sulfa Drugs
Type: Amount:
Yes / No Anticoagulants (Blood Thinners)
Amount:
Yes / No Steroids (Cortisone)
Type: Amount:
Yes / No High Blood Pressure Medication
Type: Amount:
Yes / No Tranquilizers
Type: Amount:
Yes / No Aspirin
Frequency: Amount:
Yes / No Insulin, Tolbutomide (Orinase) or Similar Drug
Type: Amount:
Yes / No Digitalis or Drugs for Heart Trouble
Type: Amount:

Yes / No Nitroglycerin
Amount:
Yes / No Tranquilizers
Type: Amount:
Yes / No Nitroglycerin
Amount:
Yes / No Oral Contraceptive or Other Hormonal Therapy
Type: Amount:
Yes / No Other Drugs:
Frequency: Amount:
Yes / No Other Drugs:
Frequency: Amount:
Yes / No Other Drugs:
Frequency: Amount:
Yes / No Other Drugs:
Frequency: Amount:

ALLERGIES

Yes / No Do you have allergies to latex?
Yes / No Do you have allergies to any medications or foods?
If so, please list:

WOMEN ONLY

Yes / No Are you pregnant?
Due Date:
Yes / No Are you nursing?

GENERAL QUESTIONS

Yes / No Have you ever taken the diet pill Phen-Fen?
Yes / No Do you use tobacco products? If so which? Cigarettes / Cigar / Pipe / Chewing Tobacco / Other
Yes / No Do you consume alcohol? If so how much? Light / Moderate / Heavy
Yes / No Do you wear contact lenses?
Yes / No Are you employed in any situation which exposes you regularly to xrays or other ionizing radiation?
Yes / No Do you have any problem or condition not listed above? Please explain:

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the patient whose name appears on this Health History form and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for dental services provided in this office for me or my dependents are due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% to 5% finance charge (18% annually) will be added to any patient balance over 60 days. IN the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party: ________________________________ Date: ____________________

Relationship to Patient: ________________________________