

Patient Name: _____

Date of Birth: _____

HEALTH INFORMATION

Date of your last dental visit? _____ Reason for this visit? _____

Have you ever had any of the following? Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Due Date _____ | |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Pace Maker | |
| | <input type="checkbox"/> Radiation Treatment | |

What prescription and non prescription medications are you currently taking? _____

Have you ever had an allergic reaction to any medication? _____ if so, list _____

Have you ever had any complications following dental treatment? ___ Yes ___ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ___ Yes ___ No

If yes, please explain: _____

Are you presently under the care of a physician? ___ Yes ___ No

If yes, please explain: _____

Name of Physician: _____ Telephone No. _____

Do you have any health problems that need further clarification? ___ Yes ___ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor and/or staff prior to my next appointment.

Signature _____

Date _____



Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Number: _____