

**Patient Health History**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

ASA \_\_\_\_\_ Circle Answer

1. Are you receiving any **medical treatment** now? Yes or No

If Yes, please explain what you are being treated for and list your doctor's name and phone number: \_\_\_\_\_

2. Please list **any medication(s)** that you are currently taking and their **purpose**:  
\_\_\_\_\_

3. Are you **allergic to** any medications/anesthetics/latex? Yes or No

If Yes, please list: \_\_\_\_\_

4. Has a physician ever informed you that you have
- a. Any heart ailment (heart attack, heart murmur, angina pectoris)..... Yes or No
  - b. High Blood pressure..... Yes or No
  - c. Diabetes..... Yes or No
  - d. Lung disease or asthma..... Yes or No
  - e. Rheumatic fever..... Yes or No
  - f. Hepatitis or liver disease..... Yes or No
  - g. Any blood disease (sickle cell, hemophilia)..... Yes or No
  - h. Kidney disease..... Yes or No
  - i. Glaucoma..... Yes or No
  - j. Any bleeding tendency (bruise easily)..... Yes or No
  - k. Tuberculosis..... Yes or No
  - l. Sexually transmitted disease (HIV/AIDS, herpes, syphilis, gonorrhea).... Yes or No
  - m. Cancer (radiation or chemotherapy?)..... Yes or No
  - n. Mental health disorder..... Yes or No
  - o. Thyroid problems..... Yes or No
  - p. Osteoporosis..... Yes or No
  - q. Artificial heart valve, artificial joint, or pacemaker..... Yes or No
  - r. Epilepsy or seizures..... Yes or No
  - s. Allergies (hay fever, sinus trouble, hives)..... Yes or No
  - t. Stroke..... Yes or No
  - u. Drug/alcohol addiction..... Yes or No

If you answered Yes above, please add pertinent information or explain any other medical conditions not listed above: \_\_\_\_\_

5. Have you **been ill, had surgery, or been hospitalized** recently? Yes or No

If Yes, please explain and supply date(s) \_\_\_\_\_

6. Have you ever fractured your jaw? Yes or No

7. (Women) Are you **pregnant or nursing**? Yes or No

9. Has a physician or previous dentist recommended that you take **antibiotics prior to your dental treatment**? Yes or No If Yes, what antibiotic and dose? \_\_\_\_\_

10. Do you **use tobacco** products? Yes or No If yes, type/frequency? \_\_\_\_\_

11. What is your preferred **pharmacy and location**? \_\_\_\_\_

**My medical history is complete and accurate**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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