Health History

PATIENT'S NAME_____ BIRTHDATE_____

PHYSICIAN'S NAME_____ PHONE (_____) _____

ADDRESS_____ CITY _____ ZIP _____

MEDICAL Circle Yes or No

1. Are you in good health ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. Date of last physical examination_____ Yes No
4. Are you now under the care of a physician? ..... Yes No
   If so, what? _____
5. Have you ever had any serious illness, operation, or hospitalization? ..... Yes No
   if so, _____
6. Are you taking any drugs or medicine? ..... Yes No
   If so, _____
7. Are you sensitive or allergic to any drugs? ❑ Penicillin or other antibiotic; ❑ Sulfa; ..... Yes No
   ❑ Codeine or other narcotic; ❑ Aspirin; ❑ barbituates; ❑ Iodine ❑ Other_____
8. Do you have, or have you had any of the following: (Please check ✓ known conditions) ..... Yes No

❑ Anemia	❑ Blood Diseases ❑ Rheumatism or Arthritis	
❑ Heart Ailments	❑ Hepatitis, Jaundice or Liver Disease	❑ Head Injuries
❑ High Blood Pressure	❑ Kidney Disease ❑ Stomach Ulcers	
❑ Respiratory Disease	❑ Tumors or Growths	❑ Venereal Disease
❑ Tuberculosis	❑ Radiation Treatment of any kind	❑ Epilepsy
❑ Aids/Arc	❑ Allergies	❑ Mental/Nervous Disorders
❑ Diabetes	❑ Asthma or Hay Fever	❑ Stroke
❑ Excessive Bleeding	❑ Fainting Spells or Seizures	❑ Glaucoma
❑ Rheumatic Fever	❑ Sinus Trouble	❑ Other _____

9. **Any Exposure to AIDS or HIV VIRUS?** ..... Yes No
10. Have you had surgery? ..... Yes No
11. Have you had any excessive bleeding requiring special treatment? ..... Yes No
12. Do you have any disease or condition or problem not listed above that you think I should know about? ..... Yes No
13. (Women) Are you pregnant or nursing? If so, how many months? _____ Yes No
14. (Women) Do you have any problems associated with you menstrual period? ..... Yes No
15. Have you ever been told by a doctor that you might have or do have a heart murmur? ..... Yes No

DENTAL

1. Previous Dentist _____ City_____
2. Have you been having any specific problem? ..... Yes No
   Explain:_____
3. Does dental treatment make you nervous? ..... Yes No
   If so, ❑ Slightly ❑ Moderately ❑ Severely
4. Do you have, or have you had any of the following: (Please check ✓ known conditions) ..... Yes No
   ❑ Bad Breath ❑ Loosening of Teeth ❑ Headaches ❑ Bleeding Gums
   ❑ Sensitive Teeth ❑ Jaws "Pop" or "Lock" ❑ Sinus Trouble
5. Have you ever had any of the following? ..... Yes No
   ❑ Injury ❑ Oral Surgery ❑ Orthodontics ❑ Periodontics
   Explain: _____
6. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
7. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
8. How long since your last dental x-rays? _____
9. How long since your last dental treatment? _____
10. Would you desire to be pre-sedated? ❑ Nitrous Oxide ❑ Drugs ❑ Or _____ Yes No
11. It is our intention to make your visit as comfortable as possible. Please comment on how we may further this for you.
    _____

Date _____ **Signature**_____

If minor, relationship to patient_____

Changes in Health _____

Date_____ **Signature**_____

Changes in Health _____

Date_____ **Signature**_____

Reviewed Summary _____

Date _____ Dr. _____

Date _____ Dr. _____

Date _____ Dr. _____

DO NOT WRITE IN THIS SPACE

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form to administer any treatment; or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.
"ALL SERVICES ARE RENDERED AND ACCEPTED UNDER THE TERMS AND CONDITIONS PRINTED ON THE REVERSE HEREOF"

Signed_____ **Date** _____
Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

Relationship _____