Health History

Name: __________________________ Social Security #: ______-____-______ Birth Date: ___________

Date of last health care exam: ___________ What was the reason for the exam: _____________

Have you been hospitalized in the last 5 years? □ YES □ NO

If yes, reason: ____

Are you currently receiving care? □ YES □ NO

If yes, nature of care: ____

Please list the names and phone numbers of the physicians who are currently providing you care:

____

____

For the following questions check YES or NO. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask you additional questions concerning your health.

	No	Yes		No	Yes
Heart Murmur (mitral valve prolapse)	□	□	Psychosis	□	□
Anemia	□	□	Sore/Enlarged Lymph Nodes	□	□
Diabetes	□	□	Previous Biopsies	□	□
Epilepsy	□	□	Slow-healing mouth sores	□	□
Hepatitis, Any Form	□	□	Other Infections	□	□
Rheumatic Fever	□	□	Recurrent Illnesses	□	□
Asthma	□	□	Joint Replacement	□	□
HIV positive or AIDS related complex	□	□	Glaucoma	□	□
Emphysema or other respiratory illnesses	□	□	Abnormal bleeding from a cut	□	□
Abnormal heart condition	□	□	Liver disease including Jaundice	□	□
Kidney Disease	□	□	Unintentional weight loss/gain	□	□
Heart (surgery, disease, attack)	□	□	Latex Sensitivity	□	□
Venereal Disease	□	□	H.I.V. Infection/AIDS	□	□

	No	Yes
Are you required to Pre-Medicate before dental treatment?	□	□
(Example: Hip replacement, knee replacement, heart valve replacement, etc.)	No	Yes
Women: Are you pregnant?	□	□
If no, are you planning a pregnancy in the near future?	□	□
Are you nursing?	□	□
Are you taking birth control pills?	□	□
Abnormal blood pressure?	□	□
If yes, what is it usually? ______________________________		
Are you allergic to, or have you had a reaction to:	No	Yes
Local anesthetics	□	□
Penicillin or other antibiotics	□	□
Aspirin	□	□
Codeine, Valium, or other sedatives	□	□
Other: ____		
Are you a smoker?	□	□

Please list any other major medical illnesses: ____

Please list any medications you are currently taking: ______________________________________

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Signature: ____ **Date:** _________________________