

## Health History

Name \_\_\_\_\_ Date of Birth (M/D/Y) \_\_\_\_\_

Mailing address \_\_\_\_\_

Occupation \_\_\_\_\_ Name of spouse (or parents if under 18) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_ e-mail \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Date last seen \_\_\_\_\_

Previous dentist /date last seen \_\_\_\_\_ Reason here today \_\_\_\_\_

**Do you have any of the conditions listed below? Please bring a written list of any prescription drugs or over-the-counter medications/herbs you take and why you take them**

	Yes	No
Allergy to penicillin		
Allergy to latex		
Major surgery in past 3 years		
Any other serious allergies		
Diabetes		
High blood pressure		
Artificial knee, hip or other joint		
Artificial heart valve		
Hemophilia /excessive bleeding		
Asthma		
Osteoporosis		
Cancer		
Heart bypass		
Heart pacemaker or defibrillator		
Other heart disease		
Arthritis		
Stroke		
Pregnant		
On birth control pills		
AIDS or HIV infection		

	Yes	No
Blood thinners (Coumadin, Plavix)		
Tuberculosis		
Frequent headaches		
Reaction/rash due to any metals		
Seasonal allergies		
Ever received chemotherapy		
Radiation therapy to jaw area		
Kidney or liver (Hepatitis) disease		
Glaucoma		
Mental illness or depression		
Anorexia or bulimia		
Epilepsy (seizures)		
Addiction to any drugs		
Smoking or chewing tobacco		
Grind or clench your teeth		
Sinus problems		
Snoring or sleep apnea		
Soda or flavored drinks daily		
Taking any medications		
Anything not listed above		

\_\_\_\_\_  
**Signature (Parent or legal guardian if under 18)**

\_\_\_\_\_  
**Date (Month/Day/Year)**