



Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_
Address: \_\_\_\_\_

When was your last physical? \_\_\_\_\_
Have you had a serious illness or injury in the past two years? [ ] Yes [ ] No
Please explain: \_\_\_\_\_

List any medications you are currently taking and their purpose.
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Are you allergic or have you reacted adversely to any of the following items? Please check those that apply.
[ ] Anesthetic [ ] Erythromycin [ ] Latex [ ] Sulfa
[ ] Aspirin [ ] Eucalyptus [ ] Nickel [ ] Tetracycline
[ ] Codeine [ ] Fluoride [ ] Nitrous Oxide [ ] Valium
[ ] Darvon [ ] Ibuprofen [ ] Penicillin
Are you aware of being allergic to any other medications or substances? [ ] Yes [ ] No
Please explain: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply.
[ ] AIDS [ ] Depression [ ] Heart Surgery [ ] Nervous Disorders
[ ] Anemia [ ] Diabetes [ ] Hemophilia [ ] Pacemaker
[ ] Angina [ ] Dizziness [ ] Hepatitis A [ ] Psychiatric Treatment
[ ] Anorexia / Bulimia [ ] Emphysema [ ] Hepatitis B [ ] Radiation Treatment
[ ] Arthritis [ ] Epilepsy [ ] Hepatitis C [ ] Rheumatic Fever
[ ] Artificial Heart Valve [ ] Fainting [ ] High Blood Pressure [ ] Seizures
[ ] Artificial Joints [ ] Hay Fever [ ] HIV [ ] Sinus Problems
[ ] Asthma [ ] Head Injuries [ ] Jaw Injury [ ] Stroke
[ ] Cancer [ ] Headaches [ ] Jaw Joint Pain [ ] Thyroid Disease
[ ] Cold Sores [ ] Heart Attack [ ] Kidney Disease [ ] Tuberculosis (TB)
[ ] Congenital Heart Disease [ ] Heart Disease [ ] Liver Disease [ ] Tumors
[ ] Cosmetic Surgery [ ] Heart Murmur [ ] Mitral Valve Prolapse [ ] Ulcers

Have you ever been dependent on drugs or alcohol? [ ] Yes [ ] No
Do you smoke or use other forms of tobacco? [ ] Yes [ ] No
Are you on a salt restricted diet? [ ] Yes [ ] No
Has your physician ever recommended taking antibiotics prior to dental appointments? [ ] Yes [ ] No
Have you ever had any adverse reactions to dental treatment? [ ] Yes [ ] No
Please explain: \_\_\_\_\_

Do you have any health conditions that need further clarification? [ ] Yes [ ] No
Please explain: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

For Women Only:
Are you pregnant? [ ] Yes [ ] No
Are you taking birth control pills? [ ] Yes [ ] No

To the best of my knowledge, all of the proceeding information provided is true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

Signature of patient, parent or legal guardian \_\_\_\_\_ Date: \_\_\_\_\_