CONFIDENTIAL

DENTAL HEATLTH INFORMATION

Although dentists primarily treat the area in and around the mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is confidential.

Patient's Name:_____

Patient Last Physical Date _____ Physician's Name _____ Physician Phone Number _____

Have you ever been hospitalized in the past two years? YES NO _____
Have you been under the care of a physician in the past two years? YES NO _____
Are you made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? YES NO _____
Are you taking Aspirin of any kind? YES NO _____
Have you ever had excessive bleeding requiring special treatment? YES NO _____

Do you have any history of:

	YES	NO	Kidney Disorders	YES	NO	HIV Positive, ARC/AIDS	YES	NO
Heart Attack	( )	( )	Ulcers or Stomach Problems	( )	( )	Alcoholism	( )	( )
Heart Disease/Attack	( )	( )	Use of Tobacco Products	( )	( )	Drug Addiction	( )	( )
Angina Pectoris	( )	( )	Emphysema	( )	( )	Glaucoma	( )	( )
Mitral Valve Prolapse	( )	( )	Tuberculosis (TB)	( )	( )	Cortisone Medicine	( )	( )
Heart Murmur	( )	( )	Breathing Problems	( )	( )	Hepatitis (Type)	( )	( )
Rheumatic Fever	( )	( )	Asthma	( )	( )	Liver Disease	( )	( )
Congenital Heart Lesions	( )	( )	Sinus Problems	( )	( )	Jaundice	( )	( )
Heart Pace Maker	( )	( )	Hay Fever	( )	( )	Blood Transfusion	( )	( )
Heart Surgery	( )	( )	Allergies or Hives	( )	( )	Excessive Bleeding	( )	( )
High Blood Pressure	( )	( )	Diabetes	( )	( )	Bleeding Disorder	( )	( )
Cancer (Type:)	( )	( )	Radiation Treatment	( )	( )	Bruise Easily	( )	( )
Anemia	( )	( )	Chemotherapy	( )	( )	Cold Sores	( )	( )
Stroke	( )	( )	Arthritis	( )	( )	Herpes	( )	( )
Epilepsy or Seizures	( )	( )	Fainting or Dizzy Spells	( )	( )	Any type of Implant	( )	( )
Psychiatric Treatment	( )	( )	Sickle Cell Disease	( )	( )	Any type of Transplant	( )	( )
Any Artificial Hip, Knee or other Joint	( )	( )	Lung Disease	( )	( )	Venereal Disease	( )	( )
Other Disease or Illness: _____						Thyroid Problem	( )	( )

List any medications you are taking including non-prescription drugs:

1. _____ 3. _____
2. _____ 4. _____

Are you allergic to any medications?:

1. _____ 3. _____
2. _____ 4. _____

WOMEN:

	YES	NO
Is there a possibility of pregnancy?	( )	( )
Estimated Delivery Date _____/_____/_____.		
Are you nursing?	( )	( )
Are you taking birth control pills?	( )	( )

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions above and acknowledge that my questions have been answered to my satisfaction.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Health History