

Name: _____ Date: _____

Please fill out the health history to the best of your knowledge

Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit: _____

Are you in good health:	Yes	No
Have there been any changes in your general health in the past year?	Yes	No
Do you have a physician? Name, Address, Phone:	Yes	No
Are you under the care of a physician for any condition? If so, for what are you being treated?	Yes	No
Have you had any illness, operation or been hospitalized in the past five years?	Yes	No
Do you have a prosthetic joint? If yes, where?	Yes	No
Do you have a heart valve replacement or vascular graft?	Yes	No

Have you had, or do you currently have:

Rheumatic fever?	Yes	No
Damaged heart valves/ mitral valve prolapse?	Yes	No
Heart murmur?	Yes	No
High blood pressure?	Yes	No
Low blood pressure?	Yes	No
Chest pain, angina?	Yes	No
Heart attack(s)?	Yes	No
Irregular heart beat?	Yes	No
Cardiac pacemaker?	Yes	No
Heart surgery?	Yes	No
Bronchitis, chronic cough?	Yes	No
Asthma?	Yes	No
Hay fever / Sinus problems?	Yes	No
Tuberculosis?	Yes	No
Emphysema?	Yes	No
Difficult breathing / other lung trouble?	Yes	No
Do you smoke?	Yes	No
Blood transfusion?	Yes	No
Blood disorder such as anemia/ sickle cell anemia / sickle cell trait?	Yes	No
Bruise easily?	Yes	No
Bleeding tendency (abnormal bleed?)	Yes	No
Jaundice, hepatitis or liver disease?	Yes	No
Eye disease / glaucoma?	Yes	No
Mental health problems?	Yes	No
Stroke?	Yes	No
Thyroid trouble?	Yes	No
Infectious mononucleosis?	Yes	No
Fainting spells / Seizures / Epilepsy	Yes	No
Diabetes?	Yes	No
Low Blood Sugar?	Yes	No
Kidney Trouble / Dialysis?	Yes	No
Swollen Ankles, Arthritis, or Joint Disease?	Yes	No
Stomach Ulcers / Hyperacidity?	Yes	No
HIV / AIDS?	Yes	No
Sexually Transmitted Disease?	Yes	No

Problems with the immune system?	Yes	No
Delayed Healing?	Yes	No
Tumor / Cancer?	Yes	No
Radiation or Chemotherapy?	Yes	No
Drug or Alcohol Abuse?	Yes	No
Contact Lenses?	Yes	No
Tobacco Use?	Yes	Never
Is there any condition concerning your health that the doctor should be told?	Yes	No
Would you like to speak to the doctor privately about anything?	Yes	No

MEDICATION

Are you taking any of the following?

Prescription or over the counter medication?	Yes	No
Vitamins or Herbal Supplements?	Yes	No
Illegal Drugs?	Yes	No
Anticoagulants? (Blood Thinners)	Yes	No
Birth Control Pills or Hormones?	Yes	No
Have you ever taken diet drugs? (ex: PhenPhen / Redux)	Yes	No
Have you ever taken any bisphosphonates? (ex: Fosamax)	Yes	No

ALLERGIES

Are You Allergic To Or Had A Reaction To...

Local anesthetics?	Yes	No
Codeine or other narcotics?	Yes	No
Penicillin?	Yes	No
Other medications?	Yes	No
Other antibiotics?	Yes	No
Latex?	Yes	No
Aspirin?	Yes	No
Other Allergies? Please list:	Yes	No

WOMEN

Is there a possibility of pregnancy?	Yes	No
Are you nursing?	Yes	No
Estimated delivery date?	Yes	No
Are you taking birth control pills?	Yes	No

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.

All of the above information is correct to the best of my knowledge. I agree to update Dr. Hall and team to any changes in my health prior to dental treatment.

Signature (Parent If Minor)

Date