HEALTH HISTORY

The following information is needed to enable us to give you the best possible treatment. In order for the doctor to thoroughly diagnose any condition, she must have accurate answers. This information is strictly confidential.

Patient Name:	Today's Date:
How would you describe your general health?	
Physician's Name:	Date of Last Physical Exam:
Physicians Phone Number:	
Have you ever been hospitalized or had major surgery?	
Have you ever had a serious head or neck injury?	

Do you have or had any of the ff:

AIDS/HIV Positive..... Y...N	Cortisone Medicine.....Y....N	Hemophilia.....Y...N	Renal Dialysis.....Y...N
Alzheimer's Disease..... Y...N	Diabetes.....Y...N	Hepatitis A.....Y...N	Rheumatic Fever.....Y...N
Anaphylaxis .....Y...N	Drug Addiction.....Y...N	Hepatitis B or C.....Y...N	Rheumatism.....Y...N
Anemia ..... Y...N	Easily Winded.....Y...N	Herpes.....Y...N	Scarlet Fever.....Y...N
Angina .....Y...N	Emphysema.....Y...N	High Blood Pressure.....Y...N	Hives or Rash.....Y...N
Arthritis .....Y...N	Epilepsy or Seizures.....Y...N	Hypoglycemia.....Y...N	Sickle Cell Disease.....Y...N
Artificial Heart Valve.....Y...N	Excessive thirst.....Y...N	Irregular Heartbeat.....Y...N	Sinus Trouble.....Y...N
Artificial Joint.....Y...N	Fainting Spells / Dizziness.....Y...N	Kidney Problems.....Y...N	Spina Bifida.....Y...N
Asthma.....Y...N	Frequent Cough.....Y...N	Leukemia.....Y...N	Intestinal Disease.....Y...N
Blood Transfusion .....Y...N	Frequent Diarrhea.....Y...N	Liver Disease.....Y...N	Stroke.....Y...N
Breathing Problem.....Y...N	Frequent Headaches.....Y...N	Low Blood Pressure.....Y...N	Swelling of Limbs.....Y...N
Bruise Easily.....Y...N	Genital Herpes.....Y...N	Lung Disease.....Y...N	Thyroid Disease.....Y...N
Cancer.....Y...N	Glaucoma.....Y...N	Mitral Valve Prolapse.....Y...N	Tonsilitis.....Y...N
Chemotherapy.....Y...N	Hay Fever.....Y...N	Pain in jaw joints.....Y...N	Tuberculosis.....Y...N
Chest Pains.....Y...N	Heart Attack/Failure.....Y...N	Parathyroid Disease.....Y...N	Tumors or Growths.....Y...N
Cold Sores/Fever Blisters.....Y...N	Heart Murmur.....Y...N	Psychiatric Care.....Y...N	Ulcers.....Y...N
Congenital Heart Disorder.....Y...N	Heart Pace Maker.....Y...N	Radiation Treatments.....Y...N	Venereal Disease.....Y...N
Convulsions.....Y...N	Heart Trouble Disease.....Y...N	Recent Weight Loss.....Y...N	Yellow Jaundice.....Y...N

Do you have any condition, disease, or problem not previously listed?

Please list all medications	Dosages

Are you allergic or had adverse reactions to any of the following?

Local Anesthetics
Penicillin or other antibiotics
Sulfa Drugs
Barbituates or sedatives
Aspirin, Acetaminophen or ibuprofen
Codeine or other narcotics
Reaction to Metals
Latex or rubber Dam

For Women Only:

Are you pregnant?
Are you nursing?
Are you taking birth control pills?
Are you taking hormone supplements?
Are you aware that some antibiotics can reduce the effectiveness of birth control?

Do you take Aspirin, Coumadin, Ibuprofen on a regular basis?

Any premedications required by physicans?

Do you take bisphosphonate medications?

Do you smoke or use tobacco? How Long? Amount?

Notes:

Patient's Signature

Reviewed by: