HEALTH HISTORY

Your Physician's name _____ Phone # _____ Last visit date _____

Your Specialist's name _____ Phone # _____ Last visit date _____

Are you currently being treated by a physician? Yes No If yes, what for ?_____

Any recent serious illness? **Yes No** If yes, what?_____

Have you ever been told you need antibiotics before dental treatment? **Yes No**

Any history of:	**Circle one**	**Please list medications here, if any**
Heart Problems	Yes No	_____
Heart Valve Problems	Yes No	_____
Heart Murmur	Yes No	_____
Rheumatic Heart Disease	Yes No	_____
History of Endocarditis	Yes No	_____
Artificial Joints or Shunts	Yes No	_____
High Blood Pressure	Yes No	_____
Kidney Disease	Yes No	_____
Liver Disease (i.e. Hepatitis)	Yes No	_____
Prolonged Bleeding	Yes No	_____
Stomach/GI Problems	Yes No	_____
Thyroid/Parathyroid Problems	Yes No	_____
Cancer	Yes No	_____
Radiation Therapy	Yes No	_____
Asthma	Yes No	_____
Epilepsy	Yes No	_____
Arthritis	Yes No	_____
Diabetes	Yes No	_____
Allergy to Anesthetic	Yes No	_____
Allergy (Seasonal)	Yes No	_____
Emotional Stress	Yes No	_____
Glaucoma	Yes No	_____
Tuberculosis	Yes No	_____
Venereal Disease	Yes No	_____
Exposure to HIV or Aids	Yes No	_____

List any health problems we should know about that are not listed above _____

Any other medications **not listed above**? (this includes all over-the-counter drugs as well as prescription drugs)

_____

Have you ever had any problems and/or addiction to prescription and/or over-the-counter drugs? _____ If so, what drugs?

_____

Are you currently undergoing substance abuse treatment for any of the drugs listed above? _____

Are you allergic to any medications? Yes No If yes, what?_____

What do you take for headaches, aches and/or pains?_____

I attest to the accuracy of the information on this page.

PATIENT OR GUARDIAN SIGNATURE _____ **DATE** _____

HEALTH HISTORY UPDATES

I have reviewed the patient's MEDICAL HISTORY, dated _______________. The patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

DENTIST OR OFFICE STAFF SIGNATURE _____________________________ **DATE** ________________

PATIENT OR GUARDIAN SIGNATURE ________________________________ **DATE** _________________

****

I have reviewed the patient's MEDICAL HISTORY, dated _______________. The patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

DENTIST OR OFFICE STAFF SIGNATURE _____________________________ **DATE** ________________

PATIENT OR GUARDIAN SIGNATURE ________________________________ **DATE** _________________

****

I have reviewed the patient's MEDICAL HISTORY, dated _______________. The patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

DENTIST OR OFFICE STAFF SIGNATURE _____________________________ **DATE** ________________

PATIENT OR GUARDIAN SIGNATURE ________________________________ **DATE** _________________

****

I have reviewed the patient's MEDICAL HISTORY, dated _______________. The patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

DENTIST OR OFFICE STAFF SIGNATURE _____________________________ **DATE** ________________

PATIENT OR GUARDIAN SIGNATURE ________________________________ **DATE** _________________

****

I have reviewed the patient's MEDICAL HISTORY, dated _______________. The patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

DENTIST OR OFFICE STAFF SIGNATURE _____________________________ **DATE** ________________

PATIENT OR GUARDIAN SIGNATURE ________________________________ **DATE** _________________

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