

**Please answer ALL questions. All information is completely confidential.**

Are you in good general health? \_\_\_\_\_ Yes No  
 Are you currently being treated for any type of illness? \_\_\_\_\_ Yes No  
 If yes, please specify here: \_\_\_\_\_  
 Name & phone # of your physician: \_\_\_\_\_  
 Are you currently taking any medication, drugs or pills? \_\_\_\_\_ Yes No  
 If yes, please list what you are taking: \_\_\_\_\_  
 \_\_\_\_\_  
 Have you been hospitalized during the past five years? \_\_\_\_\_ Yes No  
 please describe why you were hospitalized: \_\_\_\_\_

**Have you ever had, or currently have any of the following? (Please circle either Yes or No):**

Heart disease, surgery, attack -----Yes No	Cortisone medicine -----Yes No	Hepatitis (A, B, or C) -----Yes No
Heart defect -----Yes No	Fastin Pondimin (phen phen) -----Yes No	Radiation therapy -----Yes No
Heart palpitations -----Yes No	Anemia -----Yes No	Cancer -----Yes No
Artificial heart valve -----Yes No	Recent eye surgery -----Yes No	Chemotherapy -----Yes No
Heart murmur -----Yes No	Swollen ankles -----Yes No	Tumors -----Yes No
Congenital heart disease -----Yes No	Fainting, dizzy spells -----Yes No	Venereal disease -----Yes No
Mitral valve prolapse -----Yes No	Stroke -----Yes No	A.I.D.S. -----Yes No
Angina Pectoris -----Yes No	Diet -----Yes No	H.I.V. positive -----Yes No
Rheumatic fever -----Yes No	Kidney troubles -----Yes No	Herpes -----Yes No
High blood pressure -----Yes No	Ulcers -----Yes No	Cold sores, Fever blisters -----Yes No
Chest pain -----Yes No	Diabetes -----Yes No	Blood transfusion -----Yes No
Heart pacemaker -----Yes No	Thyroid problems -----Yes No	Hemophilia -----Yes No
Artificial joints, Date -----Yes No	Glaucoma -----Yes No	Sickle cell disease -----Yes No
Respiratory disorder -----Yes No	Contact lens -----Yes No	Bruise easily -----Yes No
Tuberculosis, emphysema -----Yes No	Hay fever -----Yes No	Liver disease -----Yes No
Chronic cough -----Yes No	Allergies or hives -----Yes No	Yellow Jaundice -----Yes No
Asthma -----Yes No	Sinus trouble -----Yes No	Epilepsy, Seizures. -----Yes No
Arthritis, rheumatism -----Yes No	Psychiatric or Psychological care -----Yes No	

If you have had any disease, condition, or problems not listed, please describe: \_\_\_\_\_  
 Have you taken, or currently take recreational drugs? What type? how frequently? Strictly confidential. \_\_\_\_\_ Yes No  
 Do you consume alcohol? How much? \_\_\_\_\_ Yes No  
 Tobacco in any form? How much? \_\_\_\_\_ Yes No  
 Are you or have you taken osteoporosis or cancer medication such as Fosamax, Boniva, Aredia, Zometa? \_\_\_\_\_ Yes No  
 Do you need to pre-medicate with antibiotics prior to dental treatment? \_\_\_\_\_ Yes No  
 Have you lost or gained more than 10 pounds in the past year? \_\_\_\_\_ Yes No  
 Pregnant? How many months? \_\_\_\_\_ Yes No  
 Nursing? \_\_\_\_\_ Yes No  
 Taking birth control pills? \_\_\_\_\_ Yes No

**Indicate the following drugs to which you may be allergic or sensitive. Circle yes or no for each item.**

Penicillin -----Yes No	Codeine or other narcotics -----Yes No	Local Anesthetics -----Yes No
Erythromycin -----Yes No	Aspirin -----Yes No	Non-steroidal drugs -----Yes No
Tetracycline -----Yes No	Demerol -----Yes No	Anti-inflammatory drugs -----Yes No
Sulfa drugs -----Yes No	Barbiturates or Sedative -----Yes No	Latex -----Yes No
Other antibiotics -----Yes No	Other pain medication -----Yes No	Metals -----Yes No
Other _____		

**I understand that the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.'s Initials: \_\_\_\_\_

**Annual health history updates. Please indicate changes below. If no change, please indicate no change.**

_____	Patient/Guardian initial: _____	Date: _____	Dr.'s Initials: _____
_____	Patient/Guardian initial: _____	Date: _____	Dr.'s Initials: _____
_____	Patient/Guardian initial: _____	Date: _____	Dr.'s Initials: _____
_____	Patient/Guardian initial: _____	Date: _____	Dr.'s Initials: _____
_____	Patient/Guardian initial: _____	Date: _____	Dr.'s Initials: _____