HEALTH HISTORY

Patient's Name	Home Phone	Work Phone	Cell Phone

Address	City	Zip	Email Address

Birth Date _____/_____/_____

Place of Employment & Department _____

1. Have you had a serious illness or operation within the last 2 years?..... Yes No
   If so, please explain_____
2. Are you currently under a doctor's care?..... Yes No
   If so, please explain_____
3. Have you been hospitalized during the last 2 years?..... Yes No
   If so, please explain_____
4. Are you limited in activity because of a physical or medical condition?..... Yes No
5. Are you presently under excessive emotional, mental or occupational stress?..... Yes No
6. Are you currently taking **ANY** medications, pills, drugs or syrups?..... Yes No
   If so, please list them_____
7. Do you bleed excessively when cut or during a tooth extraction?..... Yes No
8. Have you had any serious troubles associated with previous dental treatment or dental anesthetic? Yes No
9. Are you **ALLERGIC** to (Please circle):
   ANTIBIOTICS PENICILLIN CODEINE PAIN PILLS LATEX RUBBER JEWELERY METALS
   List any other allergies_____
10. Is there any other disease, condition, problem that may affect the success of your dental treatment? Yes No
11. Have you **EVER** taken any diet medications past/present?..... Yes No
12. Do you have high cholesterol? ..... Yes No
13. Do you smoke or chew tobacco products?..... Yes No
14. Do you consume more than 2 alcoholic drinks per day? ..... Yes No
15. Have you had any other serious conditions/illnesses not listed above/below?..... Yes No
    If YES, please list_____
16. Do you have or have you **EVER** had any of the following: ☐ **None Below**

- ❑ Abnormal Blood Pressure
- ❑ AIDS
- ❑ Anemia
- ❑ Angina/Chest Pain
- ❑ Arthritis
- ❑ Artificial Hip/Limb Pin/Joint/Plate
- ❑ Asthma
- ❑ Bacterial Endocarditis
- ❑ Breathing Problems
- ❑ Cancer/Tumors
- ❑ Chemo-Therapy
- ❑ Congenital Heart Problem
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Eyeglasses/Contacts
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hearing Aid
- ❑ Heart Valve Replacement
- ❑ Heart Murmur
- ❑ Heart Trouble
- ❑ Heart Surgery
- ❑ Hepatitis A (Infectious)
- ❑ Hepatitis B (Serum)
- ❑ Hepatitis C
- ❑ HIV Positive
- ❑ Kidney Trouble
- ❑ Mitral Valve Prolapse
- ❑ Nervousness
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Therapy
- ❑ Recreational Drugs
- ❑ Recovering Alcohol/Drug Abuser
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Disease
- ❑ Sinus Trouble/Sinusitis
- ❑ Stroke
- ❑ Substance Addiction
- ❑ Swelling of Ankles
- ❑ Tuberculosis
- ❑ Ulcers/Colitis
- ❑ Other _____

Women: Do you take birth control pills?..... Yes No
Are you pregnant? (If maybe circle yes) Delivery date? ..... Yes No
Are you nursing?..... Yes No

I, the undersigned (patient or legally responsible party) certify that the information given on this form is true and correct, authorize dental diagnosis and treatment to be performed by Dr. Mar/Staff and assume financial responsibility for dental services.

Signature _____ Date _____

☐ Adult Patient ☐ Father/Husband ☐ Mother/Wife ☐ Guardian