HEALTH HISTORY

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Patient: _____ Birthdate: ____/____/____

1. Do you have any current health problems? . . . . . Yes ☐ No ☐ If "Yes," please note in the "Health Problems" section
2. Are you under a physician's care now? . . . . . Yes ☐ No ☐ If "Yes," what? _____
3. Are you currently taking any medication* . . . . . Yes ☐ No ☐ If "Yes," what? _____

(*including prescription, herbal, and over-the-counter medications) _____

ALLERGIES & ADVERSE REACTIONS

CHECK THE FOLLOWING FOR WHICH YOU ARE ALLERGIC OR HAVE HAD ADVERSE REACTIONS:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics
☐ Tylenol ☐ Erythromycin ☐ Nitrous Oxide ☐ Metals
☐ Ibuprofen ☐ Sulfa ☐ Latex, Rubber Dam ☐ Other (Please describe) _____

HEALTH PROBLEMS

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

☐ Heart Problems	☐ Ulcers/Colitis	☐ Hay Fever	☐ Shortness of Breath	☐ Hepatitis/Liver Problems	☐ Sinus Problems
☐ Chest Pain	☐ Drug Dependency	☐ Skin Rashes	☐ High Blood Pressure	☐ Alcoholism	☐ Asthma
☐ Heart Murmur	☐ Psychiatric Treatment	☐ Osteoporosis	☐ Rheumatic Fever	☐ Eating Disorders	☐ Arthritis
☐ Heart Valve	☐ Diabetes	☐ Artificial Joints	☐ Artificial Heart Valve	☐ Epilepsy/Seizures/Fainting	☐ Cortisone
☐ Pacemaker	☐ Emphysema	☐ Pain in Jaw Joints	☐ Heart Surgery	☐ Glaucoma	☐ Tobacco Use
☐ Hemophilia	☐ Cancer Treatment	☐ Fen-Phen	☐ Anemia	☐ Kidney Problems	☐ HIV-positive/AIDS
☐ Bruise Easily	☐ Thyroid Disease	☐ Autoimmune Disease	☐ Abnormal Bleeding	☐ Tuberculosis (TB)	☐ Stroke
☐ Considering Pregnancy					

Premed Rx: _____

Pharmacy: _____

Primary Physician: _____

Patient/Parent Signature: _____ Date:_____

Dentist Initial: _____

UPDATES

Date: _____ Initials: _____ Changes to above: _____
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