HEALTH HISTORY

Patient's Name: ______________________ How do you prefer to be addressed? ______________

Answers to the following questions are for our records only and will be considered confidential.

1) Name of person to contact in case of emergency ______________________ Phone Number ______________

2) Date of Last Physical Examination ______________

Physician's Name ______________________ Physician's Phone Number ______________

YES/MAYBE/NO 3) Have you ever been hospitalized for any serious illness or operation? ______________

YES/MAYBE.NO 4) Have you been under the care of a medical doctor during the past two years? ______________

YES/MAYBE/NO 5) Have you taken any medicines or drugs in the past for a prolonged period of time? ______________

YES/MAYBE/NO 6) Are you allergic to latex? ______________

YES/MAYBE/NO 7) Are you allergic to (ie. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs, medications, or metals? ______________

YES/MAYBE/NO 8) Have you ever had any excessive bleeding requiring specials treatment? ______________

YES/MAYBE/NO 9) Do you have a tendency to bruise easily or bleed for a prolonged time after being cut? ______________

YES/MAYBE/NO 10) Have you ever been told that you should not give blood? ______________

YES/MAYBE/NO 11) Do you have any conditions that could effect your immune system (AIDS, HIV positive, leukemia, etc.) ______________

12) Circle any of the following which you have had or have at present:

Chest Pains	Ulcers	Alcoholism	Herpes
Heart Failure	Mental Retardation	Cortisone Medicine	Epilepsy or Seizures
Heart Disease or Attack	Emphysema	Glaucoma	Fainting or Dizzy Spells
Angina Pectoris	Cough	Pain in Jaw Joints	*Any type of Implant (heart valve, etc.)
High Blood Pressure	Tuberculosis (TB)	Birth Defects	*Heart Murmur
Asthma	HIV Positive, ARC, AIDS	Psychiatric Treatment	Disease
Rheumatic Fever	Hay Fever	Hepatitis A (infectious)	Sickle Cell Disease
*Congenital Heart Lesions	Sinus Trouble	Hepatitis B (Serum)	Bruise Easily
Thyroid Disease	Allergies or Hives	Hepatitis C	*Artificial Hip, Knee or other Joint
Heart Pacemaker	Diabetes	Liver Disease	Heart Surgery
Radiation Therapy	Jaundice	Sexually Transmitted Disease	
Cancer (Type: ________)	Chemotherapy	Blood Transfusion	Anemia
(Cancer, Leukemia)	*Any type of Transplant	Stroke	Kidney Trouble
Arthritis	Cold Sores	*Lupus	

*Antibiotic premedication may be required prior to your appointment

YES/MAYBE/NO 13) Do you smoke or chew tobacco? ______________

YES/MAYBE/NO 14) Have you ever had an adverse reaction to any injections (local anaesthetic) ______________

YES/MAYBE/NO 15) Have you ever had implant surgery in one or both of your jaws or jaw/joints? ______________

YES/MAYBE/NO 16) Are there now any growths or sores in or around your mouth? ______________

YES/MAYBE/NO 17) Do you have any trouble chewing? ______________

YES/MAYBE/NO 19) Do you have pain in or near your ears? ______________

YES/MAYBE/NO 20) Do you habitually clench or grind your teeth during the day or night? ______________

YES/MAYBE/NO 21) Have you ever been told that you have gum problems? ______________

YES/MAYBE/NO 22) Do you now have bleeding gums or any other gum condition? ______________

YES/MAYBE/NO 23) WOMEN: Are you pregnant now? ______________

YES/MAYBE/NO 24) Have you ever been warned against taking any medicine/drugs? ______________

YES/MAYBE/NO 25) History of Family Disease ______________

YES/MAYBE/NO 26) Do you get chest pains on exertion? ______________

YES/MAYBE/NO 27) Do your ankles swell? ______________

YES/MAYBE/NO 28) Have you noticed? Increased Thirst Increased Frequency Urination Unexplained Weight Loss

YES/MAYBE/NO 29) Is there anything related to your medical or dental history that you have not indicated above? If yes, explain:

____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I am delinquent in paying my account, I agree to pay interest on the overdue balance at a rate of one percent (1.5%) per month. I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that antibiotics may reduce the effectiveness of birth control pills.

SIGNATURE: ______________________ DATE: ______________

COMPLETE FOR SUBSEQUENT VISITS ONLY: I have read my answers to the health history questions listed above and there are *no* changes.

(1) ________ Initials Date	(2) ________ Initials Date	(3) ________ Initials Date	(4) ________ Initials Date
(5) ________ Initials Date	(6) ________ Initials Date	(7) ________ Initials Date	(8) ________ Initials Date
(9) ________ Initials Date	(10) ________ Initials Date	(11) ________ Initials Date	(12) ________ Initials Date