HEALTH HISTORY

Patient Name _________________ **Birthdate**______________________

Yes	No	Are you currently under a physician's care? If yes, why?
		Physician's Name:
		When was your last complete physical exam?
Yes	No	Have you ever had a serious illness or major surgery? If so, explain
Yes	No	Are you currently taking any prescription medications? List:
Yes	No	Do you routinely take health related "over the counter" medications? List:
Yes	No	Are you allergic to any medications or substances? What?
Yes	No	Do you have any other allergies? What?
Yes	No	Do you have any problems with penicillin, antibiotics, anesthetics or other meds?
Yes	No	Have you taken any cortisone/ steroid therapy during the past two years?
Yes	No	Are you sensitive to any metals, dyes or latex?
What is the source of your drinking water? ☐City ☐Well ☐Bottled ☐Reverse Osmosis		
Yes	No	**Women:** Are you ☐pregnant (due date__________) or ☐nursing?
Yes	No	Are you taking oral contraceptives?

Do you have or have you had any of the following?:

Yes	No	Artificial Joint/prosthesis/implant	Yes	No	Blood Transfusion
Yes	No	Heart Valve Implant	Yes	No	Liver Disease
Yes	No	Mitral Valve Prolapse	Yes	No	Hepatitis A, B, or C
Yes	No	Heart Disease/ Attack	Yes	No	Tuberculosis
Yes	No	Rheumatic Fever	Yes	No	AIDS/HIV Exposure
Yes	No	Heart Murmur	Yes	No	Venereal Disease/Herpes
Yes	No	High/Low Blood Pressure	Yes	No	Alcoholism/Chemical Dependency
Yes	No	Pacemaker	Yes	No	Radiation Therapy
Yes	No	Asthma	Yes	No	Cancer/Tumor
Yes	No	Sinus Problems	Yes	No	Chemotherapy
Yes	No	Epilepsy/seizures	Yes	No	Malignant Hyperthermia
Yes	No	Fainting/Dizzy Spells	Yes	No	Stomach Problems
Yes	No	Psychiatric Treatment	Yes	No	Ulcers
Yes	No	Glaucoma	Yes	No	Nervous Problems
Yes	No	Diabetes/Hypoglycemia	Yes	No	Recent Weight Loss
Yes	No	Eating Disorder	Yes	No	Sleep Apnea/Snoring
Yes	No	Circulatory Problems	Yes	No	Arthritis/Rheumatism
Yes	No	Excessive Bleeding From Cut/Injury	Yes	No	Stroke
Yes	No	Blood Diseases/Anemia/Leukemia	Yes	No	Enzyme Deficiency
Yes	No	Do you smoke or chew tobacco?	Daily Intake?		
Yes	No	Interested in quitting?			
Yes	No	Do you have any disease, condition or problem not listed?			

To the best of my knowledge, the above information is true.

Patient Signature_______________________________ Date______________ DDS init.__________