HEALTH HISTORY

Patient Name _____ DOB _____
Last First Middle

Patient Phone _____ Name of Patient Guardian - printed _____

Relationship to Patient _____ Email _____

In case of emergency, please notify _____ Relation _____ Phone _____

1. What dental problem brought you in today? _____
   _____

2. Are you presently under the care of a physician? ☐ Yes ☐ No
   If yes, doctor's name _____ Phone #: _____

3. Have you ever been hospitalized or had surgery? ☐ Yes ☐ No
   For what reason and when? _____

4. Are you pregnant? ☐ Yes ☐ No Trimester 1 2 3 Nursing? ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No

5. Do you have any of the following:

Anemia	☐	High Blood Pressure	☐	AIDS/HIV+	☐
Artificial Heart Valves	☐	Endocarditis	☐	Mental Health Issues	☐
Artificial Joints, Joint Replacement	☐	Epilepsy or Seizures	☐	Osteoporosis	☐
Asthma, Shortness of Breath	☐	Fainting	☐	Panic Attacks	☐
Autism, Sensory Disorders	☐	Handicaps/Disabilities	☐	Respiratory Disease	☐
Back, Neck Problems	☐	Hearing/Vision Loss	☐	Rheumatic Fever	☐
Bleeding Problems	☐	Heart Attack	☐	Stroke	☐
Cancer/radiation treatment	☐	Heart Murmur	☐	Swelling of Ankles	☐
Cough, Persistent	☐	Heart Pacemaker	☐	Tuberculosis	☐
Diabetes	☐	Hepatitis/Liver Disease	☐	Venereal Disease	☐
Dialysis	☐	Tobacco Use/Vaping	☐	Mouth Sores/Fever Blisters	☐
Drug Rehab	☐				

6. List any other health condition or concern _____
   _____

7. List medications that you are presently taking _____
   _____

8. Allergies? ☐ Penicillin ☐ Amoxicillin ☐ Clindamycin ☐ NSAIDS ☐ Sulfa ☐ Local Anesthetics
   ☐ Other _____

9. Pharmacy, address, phone # _____
   _____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____