## HEALTH HISTORY

1. HAVE YOU HAD, OR DO YOU PRESENTLY HAVE, ANY OF THE FOLLOWING CONDITIONS? (PLEASE CHECK YES OR NO)

HEART SURGERY, DISEASE OR ATTACK ..... YES ___ NO ___
ANGINA PECTORIS ..... YES ___ NO ___
HIGH/LOW BLOOD PRESSURE ..... YES ___ NO ___
HEART MURMUR ..... YES ___ NO ___
RHEUMATIC FEVER (RHD) ..... YES ___ NO ___
CONGENITAL HEART LESIONS (MVP) ..... YES ___ NO ___
ARTIFICIAL HEART VALVE/HEART PACEMAKER ..... YES ___ NO ___
ARTIFICIAL JOINT/PROSTHESIS ..... YES ___ NO ___
STROKE ..... YES ___ NO ___
KIDNEY DISEASE ..... YES ___ NO ___
CANCER OR TUMORS/CHEMOTHERAPY ..... YES ___ NO ___
LUNG DISEASE/TUBERCULOSIS ..... YES ___ NO ___
DIABETES ..... YES ___ NO ___
AIDS OR HIV POSITIVE: DATE TESTED _____ ..... YES ___ NO ___
HEPATITIS, JAUNDICE OR LIVER DISEASE ..... YES ___ NO ___
BLOOD TRANSFUSION ..... YES ___ NO ___
DRUG ADDICTION/ALCOHOLISM ..... YES ___ NO ___
HEMOPHILIA OR EXCESSIVE BLEEDING ..... YES ___ NO ___
COLD SORES ..... YES ___ NO ___
PSYCHIATRIC TREATMENT/MENTAL DISORDERS ..... YES ___ NO ___
ASTHMA/HAYFEVER/ALLERGIES ..... YES ___ NO ___
SINUS TROUBLE ..... YES ___ NO ___
SEIZURES/EPILEPSY ..... YES ___ NO ___
THYROID DISEASE ..... YES ___ NO ___
ARTHRITIS ..... YES ___ NO ___
OTHER _____

2. PLEASE **CIRCLE** ANY OF THE FOLLOWING YOU ARE NOW TAKING:

A. ANTIBIOTICS (WHICH?) _____
B. PAIN MEDICATION (WHICH?) _____
C. HIGH BLOOD PRESSURE MEDICATION
D. CORTISONE (STEROIDS)
E. DIGITALIS OR HEART MEDICATION
F. NITROGLYCERIN
G. ANTICOAGULANTS
H. TRANQUILIZERS (BARBITURATES)
I. INSULIN OR SIMILAR DRUG
J. LARGE DOSES OF ASPIRIN
K. ANTIHISTAMINES
L. OTHER _____

3. HAVE YOU EVER HAD AN **ALLERGIC** OR **UNUSUAL REACTION** TO ANY OF THE FOLLOWING MEDICATIONS? (PLEASE CHECK YES OR NO)

DENTAL LOCAL ANESTHETICS ..... YES ___ NO ___
ASPIRIN, ACETAMINOPHEN OR IBUPROFEN ..... YES ___ NO ___
BARBITURATE OR TRANQUILIZERS ..... YES ___ NO ___
CODEINE OR OTHER NARCOTICS ..... YES ___ NO ___
PENICILLIN/ERYTHROMYCIN/OTHER ANTIBIOTICS? ..... YES ___ NO ___
SULFA DRUGS ..... YES ___ NO ___
LATEX ..... YES ___ NO ___
ANY OTHER MEDICATIONS OR DRUGS ..... YES ___ NO ___
(WHICH?) _____

4. WOMEN: ARE YOU PREGNANT? ..... YES ___ NO ___
IF YES, HOW MANY MONTHS? _____
ARE YOU BREAST-FEEDING? ..... YES ___ NO ___
ARE YOU ATTEMPTING TO GET PREGNANT? ..... YES ___ NO ___
ARE YOU TAKING BIRTH CONTROL PILLS? ..... YES ___ NO ___

5. ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? ..... YES ___ NO ___
IF YES, FOR WHAT CONDITION _____

6. IN THE LAST FIVE YEARS HAVE YOU
BEEN HOSPITALIZED? ..... YES ___ NO ___
HAD A SERIOUS ILLNESS OR MAJOR OPERATION? ..... YES ___ NO ___
(PLEASE EXPLAIN) _____

7. IS THERE ANYTHING THE DENTIST SHOULD KNOW REGARDING YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED? ..... YES ___ NO ___
(PLEASE EXPLAIN) _____

8. HAVE YOU EVER HAD ANY SERIOUS COMPLICATIONS INVOLVING DENTAL TREATMENT? _____ YES ___ NO ___
(PLEASE EXPLAIN) _____

**TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR.**

**SIGNED:** _____ **DATED:** _____
**(PARENT OR GUARDIAN IF MINOR)**