Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: First_____Last_____

Date of Birth:_____**Social Sec. #**_____

Phone: Home_____Work_____Cell_____

Have you been under the care of a medical doctor during the past two years? YES NO

If so, for what condition? _____

Name and Address of Physician_____

Physician's phone#_____Last Physical_____

Are you taking any medications, drugs or pills, prescription or non-prescription, including aspirin? YES NO

If yes, please list name and dosage and for what condition_____

_____

_____

Is your overall general health: EXCELLENT GOOD FAIR POOR


YOU DENTAL .ORG

Please indicate which of the following you have had, or have at present. Circle YES or NO to each item.

Heart(Surgery, Disease, Attack)	**YES**	**NO**
Heart Murmur (Functional)	**YES**	**NO**
Emphysema or Asthma	**YES**	**NO**
Stroke	**YES**	**NO**
Cancer	**YES**	**NO**
Kidney Disease	**YES**	**NO**
Mitral Valve Prolapse	**YES**	**NO**
High or Low Blood Pressure	**YES**	**NO**
H.I.V./A.I.D.S	**YES**	**NO**
Diabetes	**YES**	**NO**
Cold sores or Fever blisters	**YES**	**NO**
Blood Transfusion	**YES**	**NO**
Jaundice or Liver Disease	**YES**	**NO**
Heart Pacemaker	**YES**	**NO**
Dizzy spells or fainting	**YES**	**NO**
Hemophilia or Blood Disorder	**YES**	**NO**
Thyroid Disorders	**YES**	**NO**
Stomach, Intestinal or Colon Disorders	**YES**	**NO**
Bruise Easily	**YES**	**NO**
Tumors	**YES**	**NO**
Headaches or Migraines	**YES**	**NO**
Tuberculosis or Lung Disorders	**YES**	**NO**
Hepatitis A(Infectious) B(serum) C (liver)	**YES**	**NO**
Venereal Disease	**YES**	**NO**
Artificial Heart Valve	**YES**	**NO**
Neurological Disorders	**YES**	**NO**
Radiation or Chemotherapy	**YES**	**NO**
Hay Fever or Airborne Allergies	**YES**	**NO**
Convulsions or Epilepsy	**YES**	**NO**
Artificial Joints (Knee, hip, etc)	**YES**	**NO**
Diet (Special or Restricted)	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**
Cortisone or Steroid Treatment	**YES**	**NO**
Psychiatric or Psychological Care	**YES**	**NO**

Allergies

Allergies to(Circle all that apply): **Penicillin** **Aspirin** **Codeine** **Metals** **Latex**

Local Anesthetics like Lidocaine **Other Antibiotics**_____

Other Drugs or Foods **Other**_____

Do you have any condition, disease, or problem not listed? YES NO

If yes, please describe_____

_____

Women: Are you:

Pregnant? YES NO # Months_____ Nursing? YES NO

Taking Birth Control Pills? YES NO

X _____

Patient/Guardian Signature

Changes to Medical History

Date:_____**Changes:**_____**Drs. Int.**_____**Pt. Int.**_____
Date:_____**Changes:**_____**Drs. Int.**_____**Pt. Int.**_____
Date:_____**Changes:**_____**Drs. Int.**_____**Pt. Int.**_____


YOU DENTAL .ORG