HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

DO YOU HAVE OR HAVE YOU EVER HAD:

Rheumatic Fever or Rheumatic Heart Disease…. Y N
Congenital Heart Disease………………………….. Y N
High Blood Pressure……………………………… Y N
Mitral Valve Prolapse……………………………… Y N
Asthma……………………………………………… Y N
Seizures, Convulsions, Epilepsy, Fainting……… Y N
Bruise easily, Bleeding disorder…………………. Y N
Hepatitis…………………………………………….. Y N
Kidney Disease…………………………………….. Y N
Diabetes…………………………………………….. Y N
Thyroid disease……………………………………. Y N
Arthritis………………………………………………. Y N
Stomach ulcers or colitis………………………….. Y N
AIDS/HIV Positive………………………………….. Y N
Implants placed anywhere in your body
(Heart valve, Hip, Knee, Pacemaker)…………….. Y N
Radiation treatment for cancer……………………. Y N
Grind or clench teeth, clicking/popping jaw joint Y N
Sinus or Nasal problems………………………….. Y N
Any disease, drug, or transplant operation that
has depressed your immune system……………. Y N
Are you pregnant or **<u>is there a chance</u>** you are?.. Y N
Are you taking birth control pills? ……………….. Y N

Do you smoke or chew tobacco?...................... Y N
History of Alcohol or Chemical dependency?...... Y N
Emotional disorder that may affect the care that
we provide? ………………………………………… Y N
Do you require antibiotics before dental care?..... Y N

Are you using any of the following: (Circle)
Antibiotics, Anticoagulants, Aspirin, Motrin,
Aleve, Ibuprofen, High Blood Pressure Medication
Steroids (Cortizone, etc) Tranquilizers, Insulin
Oral Anti-Diabetic Drugs, Digitalis, Inderal
Nitroglycerin or other Heart Drugs

Are you taking or have you ever taken:
Fosamax or Actonel for Oseoporosis?............... Y N
Chemotherapy for multiple myelome, etc?.......... Y N
Have you ever taken Fen-Phen/Redux?............. Y N

Please list all medication you are currently
taking including prescription and over-the-counter
medications, herbal or holistic remedies, vitamins
or mineral supplements:______________________
____
____

List any allergies:____________________________
____
____

I certify that the answers given are correct to the best of my knowledge.

Date: ___________

____
Patient Printed Name

____
Patient Signature (If 18 years or older)

____
Name of person authorized to sign for patient

____
Signature of person authorized to sign for patient