

HEALTH HISTORY

- 1. Would you categorize your general health as good, fair, or poor _____
a. Has there been any change in your general health within the past year? _____
- 2. Name and phone number of your physician _____
- 3. When was your last physical examination? _____
a. What is the condition being treated? _____
- 4. Have you been hospitalized or had any serious illness within the past five years?
a. If so, what was the problem? _____
- 5. Please (✓) any condition you have or have had in the past:

___ HIV	___ Diabetes	___ Rheumatic fever	___ Rheumatic heart disease
___ Heart attack	___ Heart trouble	___ Kidney trouble	___ Coronary insufficiency
___ Stroke	___ High blood pressure	___ Leukemia	___ Hives or skin rash
___ Anemia	___ Low blood pressure	___ Artificial joints	___ Hepatitis or Liver disease
___ Fainting spells	___ Asthma or allergies	___ Mental retardation	___ Arthritis or rheumatism
___ Seizures	___ Thyroid disease	___ Frequent headaches	___ Lost/gained weight past year

-----Mitral Valve Prolapse

Others (specify) _____
- 6. Have you any abnormal bleeding associated with previous extractions, surgery or trauma? _____
- 7. Have you had any surgery or x-ray therapy for a tumor or growth in or on the mouth, head or neck _____
- 8. Are you taking any of the following?

___ Aspirin	___ Insulin	___ Anticoagulants (blood thinners)
___ Orinase	___ Cortisone (steroids)	___ Medicine for high blood pressure
___ Tranquilizers	___ Nitroglycerine	___ Digitalis or drugs for heart trouble

Antibiotics _____
- 9. Are you allergic or have you reacted adversely to:

___ Sulfa drugs	___ Codeine	___ Local anesthetics (i.e.: Novocaine)
___ Aspirin	___ Penicillin	___ Barbiturates, sedative or sleeping pills

Others (specify) _____
- 10. Have you had serious trouble associated with any previous dental treatment?
a. If so, what? _____
- 11. Do you smoke or use tobacco in any form? _____
- 12. Is your alcohol intake none, light, moderate or heavy? _____
- 13. Are you employed in any situation, which exposes you regularly to x-rays or other ionizing radiation? _____
- 14. Do you wear a pacemaker? _____
- 15. Do you have an artificial heart valve? _____
- 16. Do you have an artificial implant or replacement? _____
- 17. Do you have any disease, condition, or problem not listed above that you think may have significant bearing on your dental health or treatment? _____
- 18. Have you ever taken Phen-Fen weight loss drugs? _____

WOMEN ONLY

- 19. Are you pregnant? _____
- 20. Are you taking oral contraceptives? _____

Signature of patient or guardian: _____ Date: _____