HEALTH HISTORY FOR DENTAL SERVICES

Fill out in blue or black ink only.

Patient's Name: ______ First | Middle | Last | Nickname | Date of Birth / / | Age | Child's Social Security Number

Home Address: ______ Street | City | Zip Code | Telephone Number ( ) | Cell Number ( )

School: ______

Health History Update	Date MM/DD/YR	Any Changes Yes	No	Date MM/DD/YR	Any Changes Yes	No	Date MM/DD/YR	Any Changes Yes	No	Date MM/DD/YR	Any Changes Yes	No
	/ /			/ /			/ /			/ /		
	/ /			/ /			/ /			/ /		

1. What is the reason for your visit today?
______
______

2. Has there been any change in your health within the past year? Yes No

3. Are you under the care of a physician? .... Yes No
   Explain: ______

4. The name and address of my physician is:
______
______

5. Have you had any serious illness or operation? .... Yes No
   If so, what was the illness or operation? ______

6. Do you use any kind of tobacco? .... Yes No

7. Do you have or have you had the following diseases or problems?
   a. ADHD .... Yes No
   b. Arthritis .... Yes No
   c. Artificial joints (hip/knee replacements) .... Yes No
   d. Asthma .... Yes No
   e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, heart murmur) .... Yes No
   f. Congenital heart lesions .... Yes No
   g. Diabetes .... Yes No
   h. Fainting spells or seizures .... Yes No
   i. Hay fever .... Yes No
   j. Hepatitis, jaundice or liver disease .... Yes No
   k. Human immunodeficiency virus (HIV/AIDS) .... Yes No
   l. Low blood pressure .... Yes No
   m. Psychiatric or psychological counseling .... Yes No
   n. Rheumatic fever or rheumatic heart disease .... Yes No
   o. Substance abuse (alcohol, drugs) .... Yes No
   p. Tuberculosis .... Yes No
   q. Venereal disease .... Yes No
   r. Other______

9. Have you ever had a serious injury to the head, face or jaw? ..... Yes No
   If so, please explain: ______

10. Are you taking any over the counter drugs? .... Yes No
    If so, please list: ______

11. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? .... Yes No
    a. Have you ever had a blood transfusion? .... Yes No
    b. Do you have a blood clotting disorder? .... Yes No
    If so, please explain: ______

12. Have you ever had radiation therapy or chemotherapy? .... Yes No

13. Are you taking any of the following?
    a. Antibiotics or sulfa drugs .... Yes No
    b. Anticoagulants (blood thinners) .... Yes No
    c. Medication for high blood pressure .... Yes No
    d. Cortisone (steroids) .... Yes No
    e. Tranquilizers .... Yes No
    f. Aspirin .... Yes No
    g. Insulin, tollbutamide (Orinase) or like drug .... Yes No
    h. Digitalis or drugs for heart condition .... Yes No
    i. Nitroglycerin .... Yes No
    j. List all current medications______

14. Are you allergic to or have you reacted adversely to?
    a. Local anesthetics .... Yes No
    b. Penicillin .... Yes No
    c. Other antibiotics, specify______
    d. Sulfa drugs .... Yes No
    e. Barbiturates, sedatives or sleeping pills .... Yes No
    f. Aspirin .... Yes No
    g. Iodine .... Yes No
    h. Codeine .... Yes No
    i. Latex .... Yes No
    j. Nickel .... Yes No
    k. Other______

15. Have you taken any medications (Fosomax, Boniva, Actonel) for Osteoporosis or Osteopenia (brittle bones) .... Yes No
    If so, please list: ______

16. Do you have any disease, condition or problem not listed above? . Yes No
    If so, please explain: ______

17. Have you used Methamphetamine, Cocaine etc. within the last 48 hours? .... Yes No

WOMEN

18. Are you pregnant? .... Yes No
19. Are you taking birth control pills? .... Yes No

STATEMENT OF CONSENT FOR HEALTH SERVICES

I hereby give my consent to all visits necessary for______ to receive an oral evaluation, dental treatment, follow-up and maintenance treatment, transportation for these services, and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the foregoing medical history questions have been accurately answered. I have been given a copy of the Department of Health's Notice of Privacy Practices.

Patient/Parent or Guardian Name: (please print) ______
Patient/Parent or Guardian Signature: ______ **Date:** ______
In Case of Emergency, please notify: ______ **Phone (_____)** ______
Dentist Signature: ______ **Date:** ______