Name _____ Birth Date _____

Health Information

• Have you ever had complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes please explain: _____

• Name of Physician: _____ Are you now under the care of a physician for a chronic condition? ☐ Yes ☐ No If yes, please explain: _____

_____

• Have you ever had any of the following:

☐ Yes ☐ No AIDS
☐ Yes ☐ No Penicillin Allergy
☐ Yes ☐ No Allergy to other medications
Explain: _____
_____
☐ Yes ☐ No Anemia
☐ Yes ☐ No Artificial Joints
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Disease
☐ Yes ☐ No Cancer
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Fainting
☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Heart Disease or Problem
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Mental Disorders
☐ Yes ☐ No Mitrol Valve Prolapse
☐ Yes ☐ No Are you pregnant?
Due Date _____
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Respiratory Problem
☐ Yes ☐ No Rheumatic Fever

☐ Yes ☐ No Osteoporosis
Medication _____
☐ Yes ☐ No Sinus Problem
☐ Yes ☐ No Stroke
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumors/Growths
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Other
_____
_____
_____

List All medications you are taking
_____
_____
_____
_____
_____
_____
_____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
_____
_____
_____
_____

I *certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.*

_____ _____
Signature of patient, parent or guardian Date: