

# Health History

(Please Circle) The information you provide is for our records and will be considered confidential.  
It is your responsibility to update this medical history when any changes occur.

- YES NO** Has there been any change in your general health within the past year?  
**YES NO** Are you under the care of a doctor for a current Problem? Reason: \_\_\_\_\_  
**YES NO** Have you been hospitalized within the past five years? Reason: \_\_\_\_\_  
**YES NO** Have you received therapy for alcoholism or drug addiction during the past five years?  
**YES NO** Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?  
**YES NO** Have you ever required a blood transfusion? Please explain: \_\_\_\_\_  
**YES NO** Have you ever had radiation for a tumor, growth, or other condition?  
**YES NO** Have you ever had Surgery? If yes please list: \_\_\_\_\_

## HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE CIRCLE):

- |                                     |  |
|-------------------------------------|--|
| JOINT REPLACEMENT (HIP, KNEE, ETC.) | HIV/AIDS                               |
| HEART MURMUR/MITRAL VALVE PROLAPSE  | VENEREAL DISEASE                       |
| HIGH BLOOD PRESSURE                 | CANCER                                 |
| HEART DISEASE                       | EMPHYSEMA                              |
| HEART ATTACK, STROKE                | ASTHMA                                 |
| BY-PASS, PACEMAKER, STINT           | SINUS TROUBLE                          |
| PROSTHETIC HEART VALVE              | EPILEPSY                               |
| ANGINA                              | NERVOUS DISORDERS                      |
| BLOOD DISORDER/ANEMIA               | PSYCHIATRIC CARE                       |
| RHEUMATIC FEVER                     | FAINTING SPELLS OR SEIZURES            |
| DIABETES                            | ARTHRITIS                              |
| THYROID PROBLEMS                    | STOMACH ULCERS, COLITIS                |
| HEPATITIS, JAUNDICE, LIVER DISEASE  | KIDNEY/BLADDER                         |
| TUBERCULOSIS                        | TEMPOROMANDIBULAR JOINT PROBLEMS (TMJ) |

**PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: (if you have a list, we will be happy to make a photocopy for your convenience)** \_\_\_\_\_

- YES NO** Do you take any blood thinners, (including aspirin)? Please List: \_\_\_\_\_  
**YES NO** Do you have any disease, condition, or problem not listed above?  
Please Specify: \_\_\_\_\_  
**YES NO** Are you allergic or sensitive to anesthetics, antibiotics, or other medications?  
Please List: \_\_\_\_\_  
**YES NO** Are you required to take antibiotics prior to dental treatment? (for heart murmur, MVP, joint replacement, etc.)

Women:

- YES NO** Are you pregnant?  
**YES NO** Are you nursing?  
**YES NO** Do you take birth control pills?  
If YES, be advised that if you take antibiotics, an alternative method of birth control must be used.

ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
DATE SIGNATURE\*

\*SIGNATURE MUST BE BY PARENT IF PATIENT IS UNDER THE AGE OF 18.

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

Date Changes in Health History