Health Information

Patient Name: _____

Physicians Name: _____ Phone: _____

Address: _____

When was your last Physical? _____

Have you had a serious illness or injury in the past two years? Yes No

Please explain: _____

List any medications you are currently taking:_____

_____

_____

Are you allergic or have you reacted adversely to any of the following items?

Anesthetic	Erythromycin	Latex	Penicillin
Aspirin	Fluoride	Nickel	Sulfa
Codeine	Ibuprofen	Nitrous Oxide	Tetracycline

Are you aware of being allergic to any other medications or substances? Yes No

Please explain: _____

Have you ever had any of the following?

AIDS	Depression	Heart Surgery	Nervous Disorders
Anemia	Diabetes	Hemophilia	Pacemaker
Angina	Dizziness	Hepatitis A	Psychiatric Treatment
Anorexia/Bulimia	Emphysema	Hepatitis B	Radiation Treatment
Arthritis	Epilepsy	Hepatitis C	Rheumatic Fever
Artificial Heart Valve	Fainting	High Blood Pressure	Seizures
Artificial Joints	Hay Fever	HIV	Sinus Problems
Asthma	Head Injuries	Jaw Injury	Stroke
Cancer	Headaches	Jaw Joint Pain	Thyroid Disease
Cold Sores	Heart Attack	Kidney Disease	Tuberculosis (TB)
Congenital Heart Disease	Heart Disease	Liver Disease	Tumors
Cosmetic Surgery	Heart Murmur	Mitral Valve Prolapse	Ulcers

Have you ever been dependent on drugs or alcohol? Yes No

Do you smoke or use other forms of tobacco? Yes No

Are you on a salt restrictive diet? Yes No

Has your physician ever recommended taking antibiotics prior to dental appointments? Yes No

Please explain: _____

Do you have any health conditions that need further clarification? Yes No

Please explain: _____

_____

_____

For Women Only:

Are you pregnant? Yes No

Are you taking birth control pills? Yes No

To the best of my knowledge, all of the proceeding information provided is true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

_____ Date: _____

Signature of patient, parent of minors or legal guardian