Health History

Last _____First_____MI____ Birthdate _____

1. How would you estimate your general health? □Poor □Fair □Good □Excellent
2. Have you been hospitalized within the last 2 years? □Yes □No
   If yes please explain:_____
3. Are you currently under the care of a physician? □Yes□ No
   If yes please explain:_____
   Physician name and contact #:_____
4. Are you currently taking prescribed medication including birth control or over the counter supplements?
   If yes please list: _____ _____ _____
   _____ _____ _____
   _____ _____ _____
5. Do you smoke or use other tobacco products Yes Never Not now, but have in the past
6. Are you now or have you ever taken a bisphosphonate (Boniva, Actonel, Fosamax)? Yes No
7. Do you need to take an antibiotic premedication prior to dental treatment? Yes No
8. The following conditions may indicate the need for antibiotic premedication prior to dental treatment. Please mark any of the following that apply:

□NONE APPLY

□Artificial Heart Valve	□Heart Valve	□Rheumatic Fever
□Artificial Joint	□Heart Surgery Problem	□Use of Phen/Redux
□Heart Murmur	□Plastic Surgery/ Implants	□Placement of Stents or other Prosthetics

DO YOU CURRENTLY HAVE, OR HAVE YOU IN THE PAST, EXPERIENCED THE FOLLOWING:

□NONE APPLY

□Allergies/Hives	□Epilepsy	□Kidney Treatment
□Anemia	□Fainting/Dizziness	□Psychiatric Treatment
□Arthritis	□ Food Allergies	□Radiation Treatment
□Alcoholism	□Glaucoma	□Sinus Trouble
□Asthma	□Chronic Headaches	□Stroke
□Bruise easily	□Head/neck Injury	□Tuberculosis
□Cancer	□Heart Attack	□Tumors
□Cold Sores	□Heart Pace Maker	□Thyroid Disorders
□Diabetes	□Hepatitis/Liver Damage	□Ulcers
□Drug Addiction	□HIV/AIDS	□High Blood Pressure

□Other:_____

DO YOU HAVE AN ALLERGY OR ADVERSE REACTION TO:

□NONE APPLY

□Aspirin, Acetaminophen, Ibuprofen	□Local Anesthetics
□Barbiturates or Sedatives	□Penicillin or other Antibiotics
□Codeine, Demerol, or other Narcotics	□Reactions to metals
□Latex or Rubber Dam	□Sulfa Drugs

□Other:_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE TO KEEP THIS OFFICE INFORMED OF ANY CHANGES IN MY HEALTH OR OF ANY MEDICATIONS I MAY BE TAKING.

Print Name:_____

Signed:_____Date:_____