# HEALTH HISTORY

Date_____

Patient Name_____

Are you now taking any medications, drugs or pills? __Yes __No
If yes please list:_____

Are you allergic to any medications? __Yes __No
If yes please list:_____

**FOR WOMEN ONLY:**
Are you pregnant? __Yes __No If yes, what month?__ If yes, are you nursing?__
Are you taking birth control pills?__

Indicate which of the following you have had or have at present. Circle "yes or no" to each item.

| | | | | | |
|---|---|---|---|---|---|
| Heart Failure | Yes No | Artificial Joints(hip,knee,etc.) | Yes No | Hepatitis B (serum) | Yes No |
| Heart Disease or Attack | Yes No | Kidney Trouble | Yes No | Venereal Disease | Yes No |
| Angina Pectoris | Yes No | Ulcers | Yes No | A.I.D.S. | Yes No |
| Congenital Heart Disease | Yes No | Diabetes | Yes No | H.I.V. Positive | Yes No |
| Heart Murmur | Yes No | Thyroid Problems | Yes No | Cold Sores/Fever Blister | Yes No |
| High Blood Pressure | Yes No | Glaucoma | Yes No | Blood Transfusion | Yes No |
| Arteriosclerosis | Yes No | Cosmetic Surgery | Yes No | Hemophilia | Yes No |
| Mitral Valve Prolapse | Yes No | Emphysema | Yes No | Anemia | Yes No |
| Artificial Heart Valve | Yes No | Chronic Cough | Yes No | Sickle Cell Disease | Yes No |
| Heart Pacemaker | Yes No | Tuberculosis | Yes No | Bruise Easily | Yes No |
| Heart Surgery | Yes No | Asthma | Yes No | Liver Disease | Yes No |
| Rheumatic Fever | Yes No | Latex Allergy | Yes No | Yellow Jaundice | Yes No |
| Arthritis | Yes No | Allergies or Hives | Yes No | Epilepsy or Seizure | Yes No |
| Rheumatism | Yes No | Sinus Trouble | Yes No | Fainting or Dizzy Spells | Yes No |
| Cortisone Medicine | Yes No | Radiation Therapy | Yes No | Nervousness | Yes No |
| Drug Addiction | Yes No | Chemotherapy | Yes No | Psychiatric Treatment | Yes No |
| Stroke | Yes No | Hepatitis A (infectious) | Yes No | Developmentally Disabled | Yes No |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date_____

Witness Signature _____ Date_____

(FOR STAFF USE ONLY)
Health History Update_____ Date_____

Health History Update_____ Date_____