NAME:_____
BIRTHDATE:_____
PHYSICIAN NAMES AND NUMBERS:
_____
_____
_____

EMERGENCY CONTACT NAMES & NUMBERS:
_____
_____

ALLERGIES AND MEDICAL NOTES:
(FOR OFFICE USE ONLY)

HEALTH HISTORY

Circle "Y" or "N" for Yes or No and note the date if you have had any of the following:

Y N Artificial Heart Valves	Y N Cortisone Treatments	Y N Psychiatric Care
Y N Heart Murmur	Y N Cough, persistent or bloody	Y N Radiation Treatment
Y N Joint Replacement	Y N Diabetes	Y N Respiratory Disease
Y N Mitral Valve Prolapse	Y N Emphysema	Y N Scarlet Fever
Y N Rheumatic Fever	Y N Epilepsy, Seizures	Y N Shortness of Breath
Y N AIDS or HIV+	Y N Fainting or dizziness	Y N Sinus Trouble
Y N Anemia	Y N Glaucoma	Y N Skin Rash
Y N Arthritis, Rheumatism	Y N Headaches	Y N Surgery
Y N Asthma	Y N Heart Problems	Y N Stroke
Y N Back Problems	Y N Hepatitis Type____	Y N Swollen feet or ankles
Y N Bleeding Abnormally, with Extractions or surgery	Y N Herpes	Y N Swollen Neck Glands
	Y N High Blood Pressure	Y N Thyroid Problems
Y N Blood Disease	Y N Jaundice	Y N Tonsilitis
Y N Cancer	Y N Kidney Disease	Y N Tuberculosis
Y N Chemical Dependency	Y N Liver Disease	Y N Tumor or growth on head or neck
Y N Chemotherapy	Y N Low Blood Pressure	
Y N Circulatory Problems	Y N Nervous problems	Y N Ulcer
Y N Contact Lenses	Y N Pacemaker	Y N Unexplained Weight Loss

Other Conditions or diseases not listed?_____
_____

Have you ever been told that you need to pre-medicate with an antibiotic prior to dental treatment? Y N
Women: Are you pregnant? Y N Due Date_____ Are you nursing? Y N

ALLERGIES (Please circle any allergies you have)
Penicillin Sulfa Drugs Codeine Aspirin Latex Anesthetic
Any other allergies not listed?_____

MEDICATIONS (Please list all medications and dosages with the correlating diagnosis)
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____ Date_____