Health Information

Previous Dentist: ________________________________ Date of Last Dental Visit: ____________

Reason for this visit: ____

Have you ever had any of the following? Please check those that apply:

___ AIDS	___ Dizziness	___ Kidney Disease	___ Stroke
Allergies __________	___ Emphysema	___ Latex Sensitivity	___Thyroid Problem
___ Epilepsy	___ Liver Disease	___Tuberculosis	___Anemia
___Excessive Bleeding	___Mental Disorders	___Tumors	___Arthritis
___Fainting	___Mitral Valve Prolapse	___Ulcers	___Artificial Joints
___Glaucoma	___Nervous Disorders	___Venereal Disease	___Artificial Heart Valve
___Growths	___Pacemaker	___Codeine Allergy	___Asthma
___Hay Fever	___Psychiatric/Psychological	___Penicillin Allergy	___Blood Disease
___H.I.V. Positive	___Pregnancy	___Allergic Reactions	___Bruise Easily
___Head Injuries	Due Date: _________	___Cancer	___Contact Lenses
___Radiation Treatment	___Cold Sores/Fever Blisters	___Heart Murmur	___Respiratory Problems
___Heart (Attack, Disease, Surgery)	___Hemophilia	___Rheumatic Fever	___Cortisone Medication
___Hepatitis	___Rheumatism	___Jaundice	___Diabetes
___High Blood Pressure	___Sinus Problems	___Smoke/Chew Tobacco	Other: _________________
___Stomach Problems	___Diet (Special/Restricted)		

Have you ever had any complications following dental treatment? Yes/No

If yes, please explain: ____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes/No

If yes, please explain: ____

Are you now under the care of a physician? Yes/No

If yes, please explain: ____

Name of Physician: ____

Phone: ____

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

If yes, please explain: ____

Are you taking any medications? Please list ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date: __________________

Signature of patient, parent or guardian

____ Date: __________________

Signature of Doctor