Health History Form

When did you last see a dentist?_____ Name:_____
Were x-rays taken?_____ If so, when?_____Date of last cleaning_____
Are you happy with your teeth, smile, etc.?_____If no, how would you like to improve it?

_____

What is the reason for your visit today?

_____

Past/Current Hx:	Yes	No		Yes	No
Lung Disease	_____	_____	Heart Disease	_____	_____
Liver Disease	_____	_____	Chest Pains	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Asthma	_____	_____
Rheumatic Fever	_____	_____	Hepatitis	_____	_____
Chronic Cough	_____	_____	HIV	_____	_____
Mitral Valve Prolapsed	_____	_____	Seizures	_____	_____

Other Major Illnesses

_____

Medications: Name:	Reason For Taking:	Frequency/Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take ANY Diet Pills? If Yes, What:

_____

Do you take ANY Natural Herbs or Health Food Supplements? If Yes, What:

_____

Allergies and Reactions to Medication?

_____

_____

Previous Surgeries:

_____

_____

Have you or anyone in your family had complications from Anesthesia? If Yes, Please explain:

_____

_____

Do You have any donor organs, artificial heart valves, joint implants or pacemaker? If Yes, Please explain:_____
Do You take aspirin on a regular basis? Yes_____ No_____
Do you have excessive bleeding or bruising? Yes_____ No_____
Do you use any Tobacco Products? Yes_____ No_____
Are you pregnant? Yes_____ No_____

Signature:_____ Date:_____