



# Health Information Form

To serve you properly we will need the following information. All information will be strictly confidential. Please print.

(Women Only) Are you pregnant? \_\_\_\_\_ If yes, what is the due date? \_\_\_\_\_

NOTE: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Family Doctor Name: \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

Are you being treated for any Medical Condition at the present?  YES  NO

If yes, what condition are you being treated for? \_\_\_\_\_

Have you ever been hospitalized or had a serious illness?  YES  NO

Have you ever had excessive bleeding following an extraction or problems clotting?  YES  NO

## Medical History

Do you have a History of:	Please circle YES or NO to each item:							
Cancer/Chemo/Radiation	Y	N	Rheumatic fever	Y	N	Anemia	Y	N
Thyroid Condition	Y	N	Heart Murmur	Y	N	Blood Transfusion	Y	N
Convulsions/Epilepsy	Y	N	Diabetes	Y	N	Sinus Problems	Y	N
Numbness/Tingling	Y	N	Heart Attack/Stroke	Y	N	Psychiatric Tx	Y	N
Dizziness/Fainting	Y	N	High Blood Pressure	Y	N	Latex Sensitivity	Y	N
Chest Pain/Discomfort	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N
Pacemaker/Heart Surgery	Y	N	Artificial Heart Valve	Y	N	AIDS/HIV	Y	N
Tuberculosis/Emphysema/Lung Disease	Y	N	Arthritis/Rheumatism	Y	N	Trigeminal Neuralgia	Y	N
Asthma/Hay fever	Y	N	Headaches	Y	N	Neck Ache	Y	N
Breathing Problems	Y	N	Joint Replacement	Y	N	Tumors/Growths	Y	N
Liver Disease/Jaundice	Y	N	Hepatitis	Y	N	Ulcers	Y	N

Are you allergic to any Local Anesthetic, Penicillin, Aspirin, Codeine, or Sulfa?  YES  NO

Please list any other allergies to medications: \_\_\_\_\_



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Please List any medications you are taking including non-prescription or herbal/vitamins:

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Are you taking or have you taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g., ZOMETA, AREDIA? (circle)  YES  NO  
 If yes, how long were they taken? \_\_\_\_\_

Do you use tobacco in any form?  YES  NO if yes, how much? \_\_\_\_\_

Do you have more than 2 alcoholic drinks per day?  YES  NO  
 Have you ever had any trouble with previous dental treatment?  YES  NO

Does dental treatment make you nervous?  NO  Slightly  Moderately  Extremely

Have you ever been treated for Periodontal Disease (Gum Disease)?  YES  NO  
 If so, when? \_\_\_\_\_

*Indicate which of the following you have had, or have at the present. Circle Yes or No to each item.*

Mouth	YES	NO	Teeth	YES	NO
Bleeding Gums			Teeth Sensitivity		
Unpleasant Taste/Bad Breath			Facial Pain		
Burning Tongue/Lips			Difficulty Chewing		
Frequent Blisters (Lips/Mouth)			Difficulty Swallowing		
Swelling/Lumps in Mouth			Does Food Pack or Catch Btwn. Teeth?		
Ortho Treatment (Braces)			Clenching/Grinding		
Clicking/Popping or Difficulty Opening/Closing Jaw			Shifting of Teeth		

How often do you brush your teeth? \_\_\_\_\_  
 How often do you floss? \_\_\_\_\_

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any changes in my health or medication.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_