Health Information

Patient Name____ Date: ________________

Do you believe you are in good health? ☐ Yes ☐ No
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:_________________

Have there been any notable changes in your health in the past 2 years? ☐ Yes ☐ No
If YES. Please describe your health changes: ____
____
Are you allergic or have you ever reacted adversely to any drug, medication or anaesthetic? ☐ Yes ☐ No
If YES. please indicate the substance(s) and reaction(s) ____
____
Have you recently taken or are you currently taking any prescription medications of ANY KIND? ☐ Yes ☐ No
If YES, please indicate the prescription medications; ____
____
Have you recently taken or are you currently taking any Non-prescription medications of ANY KIND? ☐ Yes ☐ No
If YES, please indicate the non-prescription medications; ____
Have you ever been prescribed antibiotic coverage for past dentistry? ? ☐ Yes ☐ No
If YES, please describe the antibiotics and why they were required; ______________________________________
____
Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ __________________
☐ __________________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

Do you have any other health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____
____
Are you pregnant? ☐ Yes ☐ No
If YES please specify your due date____
Do you smoke or use tobacco of any kind? ☐ Yes ☐ No If Yes, Approx. Packs/Day___________________________
Do you use recreational drugs of any kind? ☐ Yes ☐ No
If YES please specify ____

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 doctors at the next appointment without fail.

____ **Date:__________________**
Signature of patient, parent or guardian