Name: _____ **Health History**

Circle

1. Are you feeling pain or discomfort at this time?..... YES NO
2. Have you had a medical exam in the last year? ..... YES NO
3. Name of your family doctor_____ Phone # _____
4. Have you been admitted to the hospital during the past two years?..... YES NO
   If so, what was the reason for your hospitalization?_____
5. Have you had knee or hip replacement in the past 2 years? YES NO If so, please provide date._____
6. Have you had a heart attack in the last 6 months? YES NO If so, please provide date._____
7. Has your physician or dentist ever recommended you take antibiotics before dental treatment?..... YES NO
8. Please list any medications or supplements you are currently taking._____

_____

_____

9. Are you allergic or have you reacted adversely to any of the following? Please circle:

Penicillin	Sulpha	Erythromycin	Tetracycline	Local Anaesthetic
Aspirin	Codeine	Latex	Sleeping Pills	Demerol
Percodan	Seconal	Valium	Ativan	Other Antibiotics

10. Are you aware of being allergic to any other medications or substances? YES NO_____

_____

11. Circle any of the following conditions you have had:

Stroke	Diabetes	Anemia	Allergies or Hives
Heart Disease	Pacemaker	Angina	Heart Murmur
Artificial Heart Valve	Fainting/Dizziness	High Blood Pressure	Cancer/Tumor
Blood Transfusion	AIDS	HIV +	Hemophilia
Lung Disease	Asthma	Emphysema	Sinus Trouble
Liver Disease	Hepatitus: A B or C	Kidney Disease/Failure	Drug Addiction
Ulcers	Arthritis	Rheumatic Fever	Cortisone Medication
Thyroid Disease	Epilepsy/Seizure Disorder	Tuberculosis	Scarlet Fever

12. Do you have any other disease or condition not specified above? _____
13. Have you been having regular dental examinations, and hygiene appointments in the past? ..... YES NO
14. FOR WOMEN: Are you pregnant? YES NO If yes, what trimester?_____

The undersigned hereby authorizes the Dentist, upon consultation and direct consent from the Patient, to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient)_____ further to my consultation and *direct* consent. I understand that I am responsible for payment of dental services provided in this office for myself or dependants, due and payable at the time services are rendered.

Patient/Guardian Signature_____ Date:_____