we love your smile!

Health History

Preferred Pharmacy Name and Number____
Last Dental Visit ___/___/_____ Treatment Rendered______________________________________
Any injuries to face, mouth or teeth ____
My Gums… ____Healthy ____ Bleed ____Red ____Swollen ____Persistent bad breath
Do you consider your health to be: ____Excellent ____Good ____Fair ____Poor
Do you have any of the following conditions: (Please check all that apply)

__AIDS	__Epilepsy	__Psychiatric Therapy
__Allergies	__Glaucoma	__Radiation Therapy
__Anemia	__Heart Murmur	__Rheumatic Fever
__Arthritis	__Heart Problems	__Sickle Cell Anemia
__Artificial Heart Valve	__Hepatitis/Jaundice	__Sinus Problems
__Asthma	__High Blood Pressure	__Steroid Use
__Back Problems	__HIV Virus	__Stomach Problems
__Bleeding Disorder ________	__Kidney Problems	__Stroke
__Cancer	__Latex Allergy	__Thyroid Disease
__Chemotherapy	__Liver Disease	__Ulcers
__Chest Pains	__Lung Problems	__Venereal Disease
__Cholesterol	__Mitral Valve Prolapse	__Other __________
__ Diabetes	__ Nerve Problems	
__Family w/ Diabetes	__Pacemaker	

Family Physician's Name, Address and Phone Number: ____
____
Are you under a specialist care? __Yes __No If yes, please list their name, number and reason you are under their care. ____
____
Please list current medications including over the counter drugs ____________________________
____
Date and Reason for any major surgeries ____
____
Please list any allergies to medications ____
____
Have you ever had an adverse reaction to local anesthesia? __Yes __No
Do you use any tobacco products? __Yes __No Type_______________ Quantity____________
If female, are you pregnant? __Yes __No Do you take birth control pills? __Yes _No

Emergency Contact and Phone #_________________________________ Relationship_______________

Print Name____________________________ Sign_________________________________Date_________

Comments:

_________________________________ _________________________
Signature of Dentist Date