



**Health History**      patient name: \_\_\_\_\_

**Are you (or the patient) now or in the past 5 years, been under the care of a physician/medical doctor, including hospitalization(s) and surgery? Please detail:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications prescribed or over the counter (including herbal/recreational) taken in the past 30 days:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies or sensitivities to medications or materials, including latex:**

\_\_\_\_\_  
\_\_\_\_\_

**Please circle if you now have or have ever been treated for any of the following conditions:**

|                             |                     |                              |
|-----------------------------|---------------------|------------------------------|
| Heart Disease/Defects       | Kidney Disease      | Cancer                       |
| Heart Attack                | Liver Disease       | Seizures                     |
| Heart Surgery/Stents/Bypass | Ulcer/GI Disease    | Glaucoma                     |
| Heart Murmur/Replaced Valve | Blood Pressure      | Diabetes                     |
| Irregular Heart Beat        | Tuberculosis        | Neurologic Condition         |
| Pacemaker/Defibrillator     | Hepatitis           | Immune Deficiency/HIV        |
| Angina/Chest Pains          | Chemical Dependency | Tobacco Use                  |
| Fainting/Dizziness          | Thyroid/Adrenal     | Sleep Apnea                  |
| Prolonged Bleeding          | Stroke              | Currently Pregnant/Nursing   |
| Asthma                      | Replaced Joint      | Bisphosphonates/Osteoporosis |

**Approximate date of your last medical exam (physical) \_\_\_\_\_ Month/Year**

**Please detail any of the above as needed or inform us of anything else you feel we should know about including problems with prior dental treatment:**

\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, I have answered all parts completely and accurately. I will inform my dentist of changes in my health or medications.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent or guardian signature if patient is under 18 years of age

**Premedication Needed**

**Doctors Initials** \_\_\_\_\_