Health History

Name____ DOB ____________________

Reason for today's visit (in detail) ____

____

Are you allergic to any medications? Yes _____ No _____ If YES list: ______________________________

Have you ever had a dental anesthesia (Novocaine)?_____________________ Any bad reactions?__________

CIRCLE ALL THAT APPLY:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding abnormally, during surgery
- ☐ Bleeding Gums
- ☐ Blood Disease
- ☐ Blurred Vision
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Hear Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Crossed Eyes
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Ear Discharge
- ☐ Emphysema
- ☐ Epilespy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type __________
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hoarseness
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of Hearing
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Ringing in Ears
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head or Neck
- ☐ Venereal Disease

List any other disease or conditions:____

____

List **ANY** surgeries you have had and dates: ____

____

Do you drink alcohol? Yes / No How often? ____

Do you smoke? Yes / No If YES, how much? _______________________________________

Do you use smokeless tobacco? Yes / No If YES, how much? ___________________________

Do you use or have you ever used illicit drugs? Yes / No If YES, how much, how often, and what type?

____

Are you pregnant? _____________ Due date _____________ Are you nursing?___________________

Signature of Patient____ Date ______________________________