Medical/Dental Health History
Please check all that apply

	Yes	No
Heart Problems		
Chest Pain	☐	☐
Blood pressure problems	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Mitral valve prolapse	☐	☐
Blood Problems		
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g. knee, hip)	☐	☐
Allergy Problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Allergic to latex	☐	☐
Other Problems		
Fainting spells, Seizures or Epilepsy	☐	☐
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Cancer/Tumor	☐	☐
Hepatitis, Jaundice or Liver Trouble	☐	☐
Herpes	☐	☐
HIV-Positive/AIDS	☐	☐
Glaucoma	☐	☐
Wear Contact Lenses?	☐	☐
Past or present chemo/radiation therapy	☐	☐

Allergy to Medication

Are you allergic to, or have you reacted adversely to, any of the following:

	Yes	No
Local anesthetics (Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Sulfites	☐	☐
Other	☐	☐

Please specify: _____

	Yes	No
Are you under a doctor's care at this time?	☐	☐

If yes, for what condition? _____

Doctor's name? _____

Are you currently taking any medications?	☐	☐

If yes, what medications(s)? _____

_____

_____

Women

Are you taking oral contraceptives or other hormones	☐	☐
Are you pregnant?	☐	☐

If yes, expected delivery date _____

Dental Information

How long has it been since you have seen a dentist?

_____

	Yes
Apprehensive about dental treatment?	☐
Have you had problems with previous dental treatment?	☐
Have you ever had a difficult extraction?	☐
Have you had any periodontal (gum) treatment?	☐

Indicate any other disease, condition or problem not listed above:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature (Parent, if minor) _____ **Date** _____