

Patient Name: _____

Medical/Dental Health History

Please check all that apply

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

Allergy to Medication

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

	Yes	No
Local anesthetics (Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfites	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Please specify: _____

	Yes	No
Are you under a doctor's care at this time?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for what condition? _____		
Doctor's name? _____		
Are you currently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>
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** _____