HEALTH HISTORY

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip_____

Cell: _____ Work: _____ Home: _____ Email: _____

Primary Care Physician:_____ Phone:_____

Women: Are you pregnant? __Yes __No Are you nursing? __Yes __No Birth control pills? __Yes __No

CHECK ALL THAT APPLY:

____ AIDS/HIV	____ Stroke/ TIA	____ Diabetes	____ Lung Disease
____ Artificial Heart Valves	____ Artificial Joints	____ Pacemaker	____ Asthma
____ Heart Problems	____ Blood Disease	____ Hemophilia	____ Cancer
____ Hepatitis A, B or C	____ Chemical Dependency	___ High Blood Pressure	

≈Any additional information you feel we should be aware of or any explanation needed for the above:

_____

_____

MEDICATIONS:

List medications you are taking and reason

1._____ for _____

2._____ for _____

3._____ for _____

4._____ for _____

5._____ for _____

ALLERGIES:

Please check next to appropriate one(s)

_____ Codeine / Tylenol 3	_____ Clindamycin / Cleocin
_____ Erythromycin / Zpak	_____Foods
_____ Ibuprofen / Motrin	_____ Latex
_____ Penicillin / Amoxicillin	_____ Vicodin / Norco
_____ Tetracycline / Doxycycline	_____ No Known Allergies

_____ Other_____

6. Are you taking bisphosponate or other medications to build bone density or for cancer treatment? Yes / No

7. Are you taking blood thinners (Aspirin, Coumadin, Plavix, Eliquis, etc)? Yes / No

AUTHORIZATION & ACKNOWLEDGEMENT

I certify that I have read and understand the above health history. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____