

HEALTH HISTORY

- ARE YOU IN GOOD HEALTH? YES NO
- ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? YES NO
IF YES, PLEASE EXPLAIN _____

- HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 2 YEARS? YES NO
FOR WHAT REASON? _____

- PLEASE LIST ANY MEDICINES OR DRUGS YOU ARE CURRENTLY TAKING: N/A

- PLEASE LIST ANY ALLERGIES YOU HAVE TO ANY DRUGS SUCH AS ANTIBIOTICS (LIKE PENICILLIN), LOCAL ANAESTHETICS (LIKE NOVACAINE), PAIN MEDICATION, OR ANY OTHER: N/A

- ARE YOU ALLERGIC TO LATEX? YES NO
- DO YOU HAVE TO PRE-MEDICATE WITH ANTIBIOTICS BEFORE DENTAL TREATMENT? YES NO
IF YES, THEN WHY? _____

- DO YOU TAKE ANY BLOOD THINNERS (COUMADIN, PLAVIX, ETC), STEROIDAL MEDICATIONS (EMBREL, CORTISONE, ETC) OR OSTEOPOROSIS MEDICATIONS (FOSAMAX, BONIVA, ETC)? YES NO
IF SO, PLEASE LIST SPECIFIC MEDICATION _____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

ARTHRITIS ASTHMA BLEEDING PROBLEMS CANCER DIABETES EPILEPSY HEART MURMER HEART PROBLEMS (PLEASE SPECIFY) _____ _____	HEPATITIS HERPES HIGH BLOOD PRESSURE HIV + JAUNDICE KIDNEY PROBLEMS LOW BLOOD PRESSURE RHEUMATIC FEVER STROKE TUBERCULOSIS	AUTO IMMUNE DISORDER/DISEASE (PLEASE SPECIFY) _____ ARTIFICIAL JOINT REPLACEMENT (WHEN?) _____ FEMALE PATIENTS: ARE YOU PREGNANT? YES NO IF YES, WHEN IS YOUR DUE DATE? _____
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- ADDITIONAL NOTES OR CONCERNS THAT WOULD BE HELPFUL FOR THE DOCTOR TO KNOW
