

Patient Number _____

HEALTH HISTORY

Page 2

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING TREATMENTS:

- | | |
|---|---|
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Radiation treatments | |

Please initial if
nothing checked

CHECK IF YOU ARE TAKING ANY OF THE FOLLOWING:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigarettes or tobacco of any form |
| <input type="checkbox"/> Natural or herbal remedies | <input type="checkbox"/> Over the counter medicines (e.g. Aspirin) |
| <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Weight loss products |

Please initial if
nothing checked

If you checked any of the above, please explain: _____

FEMALE PATIENT ONLY:

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you or could you be pregnant or nursing? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you taking birth control pills? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any problem related to your menstrual period? |

ALL PATIENTS:

- Yes No Do you have or have you had any other disease or medical problem NOT listed on this form?

If yes, please explain: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any change in my medical status.

PATIENT or GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____