PATIENT HEALTH HISTORY INFORMATION

15.1

Date: Patient Name (Last, First, MI): Birth Date

Prior Dentist / Dental Clinic Name: City / State: Last Dental Exam: Last Dental XRay:

Physician / Medical Clinic Name: Last Physical Exam:

Do you smoke or use tobacco products? ☐ Yes ☐ No

ALLERGIES - Select all that apply:

☐ Aspirin Allergy ☐ Codeine Allergy ☐ Erythromycin Allergy ☐ Hay Fever ☐ Latex Allergy

☐ Penicillin Allergy ☐ Sulfa Allergy ☐ Other Allergy:

MEDICAL CONDITIONS - Please select all that apply:

☐ Anemia ☐ Arthritis ☐ Artificial Joints ☐ Asthma

☐ Blood Disease ☐ Cancer ☐ Diabetes ☐ Dizzy Spells or Fainting

☐ Epilepsy or Seizures ☐ Excessive Bleeding ☐ Glaucoma ☐ Head Injury

☐ Heart Condition ☐ Heart Disease ☐ Heart Murmur ☐ Heart Pacemaker

☐ Hemophilia ☐ Hepatitis A (Infectious) ☐ Hepatitis B (Serum) ☐ Hepatitis C or Other

☐ Herpes ☐ High Blood Pressure ☐ HIV + / AIDS ☐ Jaundice

☐ Kidney Disease/Trouble ☐ Liver Disease ☐ Low Blood Pressure ☐ Mental Disorder

☐ Nervous Disorder ☐ Osteoporosis ☐ Pregnant or Nursing ☐ Radiation Therapy

☐ Respiratory Problems ☐ Rheumatic Fever ☐ Rheumatism ☐ Sexually Trans. Disease

☐ Sinus Trouble ☐ Stomach Problems ☐ Stroke ☐ Tuberculosis (TB)

☐ Tumors ☐ Ulcers ☐ Other Condition:

MEDICATIONS - Please list any medications you are currently taking:

☐ Please check this box if you are taking additional medications not listed here, and bring a list along to your appointment.