



# Health History Form

Patient's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Do you or have you had? (select all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> (1) High Blood Pressure | <input type="checkbox"/> (7) H.P.V.           | <input type="checkbox"/> (13) Diabetes            | <input type="checkbox"/> (19) Epilepsy     |
| <input type="checkbox"/> (2) Heart Trouble       | <input type="checkbox"/> (8) Hepatitis        | <input type="checkbox"/> (14) Bleeding Tendencies | <input type="checkbox"/> (20) Acid Reflux  |
| <input type="checkbox"/> (3) Pace Maker          | <input type="checkbox"/> (9) HIV Positive     | <input type="checkbox"/> (15) Stroke              | <input type="checkbox"/> (21) Tobacco Use  |
| <input type="checkbox"/> (4) Artificial Joint    | <input type="checkbox"/> (10) Tuberculosis    | <input type="checkbox"/> (16) Asthma              | <input type="checkbox"/> (22) Other: _____ |
| <input type="checkbox"/> (5) Osteoporosis        | <input type="checkbox"/> (11) Substance Abuse | <input type="checkbox"/> (17) Sleep Apnea         | _____                                      |
| <input type="checkbox"/> (6) Head/Neck Cancer    | <input type="checkbox"/> (12) Eating Disorder | <input type="checkbox"/> (18) Organ Transplant    | _____                                      |

Are you taking any medication now?  Yes  No (Please attach list if necessary)

Medication Name

Reason for medication

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you need to pre-medicate with antibiotics before dental appointments?  Yes  No

If yes, why? \_\_\_\_\_

Any allergies or complications with:

- Latex  Novocaine  Narcotics  Dental Materials  Penicillin  Other: \_\_\_\_\_

Are there other conditions we should know about? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Under physician's care now? \_\_\_\_\_ If so, for what? \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_ If so, due date? \_\_\_\_\_

Are you taking birth control pills? \_\_\_\_\_

**I authorize the following person(s) to request and/or discuss my protected dental health information (i.e.family member, parent):**

**By signing below, you authorize that this information is correct to the best of your knowledge. You understand that your consent to disclose protected health information is valid for three years and may be revoked at any time in writing.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*FOR OFFICE USE ONLY\*\*\***

Health History Review:

**Referral Source:** \_\_\_\_\_

Initials \_\_\_\_\_