Health History Form

Patient's Name _____ **Birth Date** _____

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

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

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 _____