



# Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> AIDS<br><input type="checkbox"/> Allergies _____<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial Joints<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Head Injuries<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> <b>Pregnancy</b><br>Due date: _____<br><input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Codeine Allergy<br><input type="checkbox"/> Penicillin Allergy<br><input type="checkbox"/> OTHER:<br><input type="checkbox"/> Tobacco Use (smoking, other)<br><input type="checkbox"/> _____ |
|---|---|--|

- Have you ever had complications following dental treatment? Yes No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician? Yes No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification? Yes No  
If yes, please explain: \_\_\_\_\_
- List all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend, Another patient, relative  
Dental Office Yellow Pages Newspaper Website Work Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

|  |   |
|--|---|
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |
| _____<br>Patient's Signature <span style="float: right;">Date</span> | _____<br>Doctor <span style="float: right;">Date</span> |