Personal Health Information

Patient Name: ____ Date: _______________

Are you allergic to?
❑ Latex ❑ Dental Anesthetics ❑ Penicillin ❑ Erythromycin ❑ Aspirin ❑ Codeine ❑ Sulfa ❑ Metals
❑ Other: ____

Do you use tobacco products? ❑ Yes ❑ NO ❑ Cigarettes ❑ Pipes ❑ Chew ❑ Dip ❑ Daily ❑ Seldom
Consume alcohol beverages? ❑ Yes ❑ NO ❑ Daily ❑ Seldom

WOMEN: Are you or do you think you might be pregnant? ❑ Yes ❑ NO Are you nursing? ❑ Yes ❑ NO

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had or do you currently have any of the following? List medication(s) or drug(s) taken for the condition.

❑ Yes ❑ NO Heart Disease Medication ________________________ Notes ________________
❑ Yes ❑ NO Heart Attack Medication ________________________ Notes ________________
❑ Yes ❑ NO Chest Pains Medication ________________________ Notes ________________
❑ Yes ❑ NO Stroke Medication ________________________ Notes ________________
❑ Yes ❑ NO Rheumatic Fever Medication ________________________ Notes ________________
❑ Yes ❑ NO Mitral Valve Prolapse Medication ________________________ Notes ________________
❑ Yes ❑ NO Congenital Heart Disease Medication ________________________ Notes ________________
❑ Yes ❑ NO Artificial Heart Valves Placed when ________________________ Notes ________________
❑ Yes ❑ NO Heart Pacemaker Placed when ________________________ Notes ________________
❑ Yes ❑ NO High Blood Pressure Medication ________________________ Notes ________________
❑ Yes ❑ NO Blood Transfusion When ________________________ Notes ________________
❑ Yes ❑ NO Epilepsy or Seizures Medication ________________________ Notes ________________
❑ Yes ❑ NO Drug Addiction/Alcoholism Medication ________________________ Notes ________________
❑ Yes ❑ NO Implants Type ________________________ Notes ________________
❑ Yes ❑ NO Kidney Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Thyroid Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Liver Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Mental Health Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Bleeding Problems or Hemophilia
❑ Yes ❑ NO Genetic Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Hormonal Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Lung Problems Medication ________________________ Notes ________________
❑ Yes ❑ NO Venereal Disease Medication ________________________ Notes ________________
❑ Yes ❑ NO A.I.D.S. / H.I.V. Positive Medication ________________________ Notes ________________
❑ Yes ❑ NO Cortisone/Steroids Medication ________________________ Notes ________________
❑ Yes ❑ NO Persistent Cough Medication ________________________ Notes ________________
❑ Yes ❑ NO Artificial Joints Type ________________________ Notes ________________
❑ Yes ❑ NO Asthma Medication ________________________ Notes ________________
❑ Yes ❑ NO Cancer Type ________________________ Notes ________________
❑ Yes ❑ NO Sinus Trouble Medication ________________________ Notes ________________
❑ Yes ❑ NO Allergies Medication ________________________ Notes ________________
❑ Yes ❑ NO Arthritis Medication ________________________ Notes ________________
❑ Yes ❑ NO Hepatitis Medication ________________________ Notes ________________
❑ Yes ❑ NO Diabetes ❑ Yes Type II Medication ________________________ Notes ________________
❑ Yes ❑ NO Tuberculosis Medication ________________________ Notes ________________

List any medications/vitamins/supplements not listed above: ___________________________________

____

Name of Your Physician: ___________________________________ Phone # ________________

Are you currently under the care of a physician? ❑ Yes ❑ NO If yes, for what reason? ____________

____

Have you been hospitalized within the past 12 months? ❑ Yes ❑ NO   If yes, for what reason?

____

Please read the paragraph below and sign. Your signature will indicate that you have read the paragraph and agree to these statements.

The information given above regarding the patient medical and dental histories is accurate and complete to the best of my knowledge. I will not hold the dentist or her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any changes occur, it is my responsibility to inform the dentist and her staff.

Patient/Guardian Signature: ______________________________________Date: _______________

For Office Use Below

I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: __________ Date: _______________ Initials: ______________ Date: ______________