Health History – New Patient

Name: _____ Birthdate: _____
Date of last dental care _____ Date of last dental xrays _____
Any dental concerns we should be aware of: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, Please explain:

_____

Have you ever had a serious head or neck injury? Yes No Do you use Tobacco? Yes No
Have you ever taken Phen Fen or Redux? Yes No Are you on a special diet? Yes No
Do you wear contact lenses: Yes No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? Yes No
Women: Pregnant/Trying to get pregnant? Yes No Nursing? Yes No
Taking Oral Contraceptive pills? Yes No

Allergies – Circle all that apply:
Aspirin Penicillin Antibiotic Codeine Sulfa Sedatives Latex Local Anesthetics
Other, Please Explain: _____

Please circle yes or no to indicate if you have had any of the following:

Aids / HIV	Yes No	Cold Sores / Herpes	Yes No	Irregular Heartbeat	Yes No
Allergies / Hay Fever	Yes No	Congenital Heart Disorder	Yes No	Kidney Problems	Yes No
Alzheimer's Disease	Yes No	Convulsions	Yes No	Leukemia	Yes No
Anaphylaxis	Yes No	Cortisone Medicine	Yes No	Liver Disease	Yes No
Anemia	Yes No	Diabetes	Yes No	Low Blood Pressure	Yes No
Angina	Yes No	Drug Addiction	Yes No	Mitral Valve Prolapse	Yes No
Arthritis / Gout	Yes No	Emphysema	Yes No	Pain in Jaw Joints	Yes No
Artificial Heart Valve	Yes No	Epilepsy or Seizures	Yes No	Radiation Treatments	Yes No
Artificial Joints	Yes No	Excessive Bleeding	Yes No	Renal Dialysis	Yes No
Asthma	Yes No	Fainting Spells / Dizziness	Yes No	Shingles	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Sinus Trouble	Yes No
Breathing Problems	Yes No	High Blood Pressure	Yes No	STD's	Yes No
Bruises Easily	Yes No	Heart Attack / Failure	Yes No	Stomach/Intestinal Disease	Yes No
Cancer	Yes No	Heart Murmur	Yes No	Stroke	Yes No
Chemotherapy	Yes No	Hepatitis Type ____	Yes No	Thyroid Disease	Yes No
Chest Pains	Yes No	Hives or Rash	Yes No	Tuberculosis	Yes No

Other: _____

Please list all medications and drugs you are taking: _____

_____

I have read and answered the above questions to the best of my knowledge and understand the importance of a truthful health history to assist the doctor in providing the best care possible.

_____ _____
Patient/Parent/Guardian Signature Date