Do you have, or have you had, any of the following:

AIDS/HIV Positive	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Hepatitis A, B or C	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Angina	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Bruxism/Grinding Teeth	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Pain in Jaw Joints/		
Celiac Disease	☐ Yes	☐ No	TMJ Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Convulsions/Epilepsy or Seizures	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sexually Transmitted Infection	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No

To the best of my knowledge, the questions on this form (Two Pages Health History) have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's Name _____ Signature _____ Date _____

Health History

Do you get medical check ups on a regular basis? ☐ Yes ☐ No

Are you currently being treated by a medical professional for any condition unrelated to dentistry? ☐ Yes ☐ No

Have you been hospitalized or had a major operation? ☐ Yes ☐ No

Please List: _____

_____

Do you have or have you been treated for any lung conditions? (Asthma, COPD, Emphysema, Sleep Apnea, etc.) ☐ Yes ☐ No

Have you ever been treated for osteoporosis? When? _____ ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Please Describe: _____

Are you taking any medications, pills, drugs, vitamins, supplements (women please include contraceptions)? ☐ Yes ☐ No

Please List: _____

_____

Do you take, or have you taken, Phen-fen or Redux? ☐ Yes ☐ No

Do you use tobacco? Please list _____ ☐ Yes ☐ No

Do you require antibiotic premedication? ☐ Yes ☐ No

If yes, when and why and duration were you told you need antibiotic premedication.

How long do you require premedication?

_____

Have you ever been treated for cancer? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any issues with being able to recline back in a dental chair? ☐ Yes ☐ No

WOMEN ONLY

Pregnant or trying to get pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetic ☐ Seasonal

☐ Other Please List: _____

Complete Page 2 of Health Form on other side. Please turn over.