PATIENT HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

Primary Physician:_____ Pharmacy:_____

Do you have, or have a history of, any of the following?

- ☐ **Abnormal Blood Pressure**
- ☐ **AIDS**
- ☐ **Anemia**
- ☐ **Angina**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Congenital Heart Lesions**
- ☐ **Diabetes**
- ☐ **Drug Dependency**
- ☐ **Epilepsy**
- ☐ **Fainting**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **Herpes**
- ☐ **Jaundice**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Organ Transplant**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Prolonged Bleeding**
- ☐ **Prolonged Cough**
- ☐ **Radiation Therapy**
- ☐ **Rheumatic Fever**
- ☐ **Sickle Cell Anemia**
- ☐ **Sleep Apnea**
- ☐ **Snoring**
- ☐ **Thyroid Disease**
- ☐ **Tobacco Habit**
- ☐ **Tuberculosis**
- ☐ **Venereal Disease**

Have you had surgery in the last 6 months? If so, please explain:_____

_____

Are you allergic to:

- ☐ **Codeine**
- ☐ **Penicillin**
- ☐ **Latex**
- ☐ **Other:**_____

_____

_____

List of Medications

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____**Date:**_____

Reviewed On: **Initial Here:**	**Reviewed On:** **Initial Here:**	**Reviewed On:** **Initial Here:**	**Reviewed On:** **Initial Here:**