HEALTH HISTORY

Printed Name _____

Date of Last Dental Visit ___/___/___ Reason for This Visit _____

Have You Ever Had Any of the Following? Please Check Those that Apply:

☐ AIDS or HIV+	☐ Cortisone	☐ Hepatitis	☐ Rheumatism
☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problems
☐ Anemia	☐ Dizziness	☐ Jaundice	☐ Stomach Problems
☐ Arthritis	☐ Emphysema	☐ Kidney Disease	☐ Stroke
☐ Artificial Heart Valve	☐ Epilepsy/Seizures	☐ Latex Allergy	☐ Thyroid Problems
☐ Artificial Joints	☐ Excessive Bleeding	☐ Liver Disease	☐ Tuberculosis
☐ Asthma	☐ Fainting	☐ Mental Disorders	☐ Tumors
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Blood Transfusion	☐ Growths	☐ Neurological Disorders	☐ Venereal Disease
☐ Bruise Easily	☐ Hay Fever	☐ Pacemaker	☐ Codeine Allergy
☐ Cancer	☐ Head Injuries	☐ Psychological Care	☐ Penicillin Allergy
☐ Chemotherapy	☐ Heart Disease	☐ Radiation Treatment	☐ Chest Pains
☐ Heart Murmur	☐ Respiratory Problems	☐ Cold Sore/Fever Blister	☐ Hemophilia
☐ Rheumatic Fever	Other _____		

Please List All Medications _____

_____

Please List All Allergies _____

- Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
  If yes, please explain _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain _____
- Have you been admitted to a hospital during the past two years? ☐ Yes ☐ No
  If yes, please explain _____
- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain _____

Name of Physician _____ **Phone** _____

Women

Are you pregnant? _____	☐ Yes, ____ months ☐ No
Are you nursing? _____	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No

INFORMED CONSENT STATEMENT

This is to certify that I consent and hereby authorize and request the performance upon myself/child dependent of any needed dental or oral surgical procedure as recommended to me by the dentist. I also authorize and request the administration of anesthetic(s) for myself/my minor child/my dependent as may be deemed necessary or advisable by the doctor. I acknowledge the possible risks and complications involved during and after the performance of all dental procedures, surgeries and delivery of anesthetic. I also acknowledge that I will have the opportunity to ask and have any and all of my questions regarding these risks answered before treatments begin. I fully understand that during, and following the contemplated procedures, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternate treatment pertinent to the success of comprehensive treatment. I also approve of any modifications in design, materials or care if it is felt that it is for my best interest. I have been informed and understand that the practice of dentistry is not an exact science and that no guarantees or assurances as to the outcome of dental treatment or surgery can be made.

Signature of Patient or Guardian _____

Witness _____ **Date** _____