Health History

Referred By _____
Family Dentist _____
Family Physician _____

What service is to be performed today?_____

Yes or NO

_____ Are you under the care of a **Physician** now?
_____ Are you currently taking **Any Medication**? Please List_____
_____ Are you **Allergic to any Medication**? Please List_____
_____ Are you taking **Blood thinners, Aspirin or Aspirin-containing** medication?
_____ Have you ever taken **Cortisone** or been on **Steroid therapy**?
_____ Have you or any family member ever had any reactions to anesthesia? Explain_____
_____ Do you smoke?
_____ Have you used any illegal medications or drugs in the last 24 hours?
_____ Do you take or have you ever taken (**Fosamax, Actonel, Boniva, Aredia or Zometa**)? Please Circle
_____ **Women**, Are you **Pregnan**t or **possibly pregnant**?

Have you **had** or **do you have** any of the following? **(Please Circle)**

Asthma	**Blood Transfusion**	**Cancer**	**Diabetes**
Heart Murmur	**High Blood Pressure**	**Hepatitis**	**Autoimmune Diseases**
Kidney Disease	**Bleeding Disorder**	**Ulcers**	**Infectious Disease**
Major Operations	**Heart Disease/Attack**	**Radiation**	**Osteoporosis**
Liver Disease	**Organ Transplant**	**Anemia**	**Chemotherapy**
Hip Replacement	**Valvular Disease**	**Seizures**	**Bypass Surgery**
Rheumatic Fever	**Congenital Heart Disease**	**Stroke**	**Pacemaker**
Tuberculosis	**Thyroid Disease**	**Glaucoma**	**Arthritis**

Is there Anything else we should know?_____

For Women Only:

1. If you are using oral contraceptives it is important that you understand the antibiotics and other medications may interfere with the effectiveness of the contraceptive. Please consult your physician for further guidance.
2. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm you developing baby, especially during the first trimester. Please advise your doctor if there is any chance of you being pregnant.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient (Parent if patient is under 18 years of age) Date