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**Health History**

Date \_\_\_\_\_

Name \_\_\_\_\_

Physician's Name & Phone Number \_\_\_\_\_

Is patient currently receiving care? \_\_\_\_\_ Why \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**Drug allergies**, such as Penicillin \_\_\_\_\_

Do you take any kind of **blood thinners**? \_\_\_\_\_

Has the patient ever had complications or prolonged bleeding following surgery? \_\_\_\_\_

Is patient allergic to any metals or jewelry? \_\_\_\_\_

Has patient had any unusual reaction to local anesthesia? \_\_\_\_\_

**Please check any of the following, which the patient may have had or currently has:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Rheumatic fever          | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney or Liver |
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> AIDS or AIDS related  | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Prosthetic joints     | <input type="checkbox"/> Sinus problems  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Infectious hepatitis  | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Drug/Alcohol dependency | <input type="checkbox"/> Physical/Mental Handicap |  |  |

**Dental History**

Date of the patient's most recent dental visit \_\_\_\_\_ Reason \_\_\_\_\_

Is the patient having any discomfort at this time? \_\_\_\_\_ If yes, why \_\_\_\_\_

Please indicate any of the following, which are of concern:

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Bleeding gums   | <input type="checkbox"/> Mouth odor          | <input type="checkbox"/> Sensitivity to hot/cold  | <input type="checkbox"/> Dry mouth   |
| <input type="checkbox"/> Color of teeth  | <input type="checkbox"/> Pain in/around ears | <input type="checkbox"/> Sensitivity to sweets    | <input type="checkbox"/> Flossing    |
| <input type="checkbox"/> Brushing habits | <input type="checkbox"/> Lip/mouth ulcers    | <input type="checkbox"/> Sensitivity when chewing | <input type="checkbox"/> Loose teeth |

Please comment on any other health or dental considerations: \_\_\_\_\_

Patient Signature \_\_\_\_\_