Health History

Height: _____ Weight: _____ Date of last medical examination: _____

Are you being treated for any medical problems? Yes ☐ No ☐ If so, please explain _____

Women, are you pregnant? Yes ☐ No ☐ If so, how many weeks? _____

Do you pre-medicate before having dental work due to heart problems or prosthetic joints? Yes ☐ No ☐

If so, please explain _____ What medication do you take? _____

Have you ever had any of the following diseases or medical problems?

Medical problem	Yes	No
Abnormal bleeding		
Alcohol Abuse		
Anemia		
Artificial joints/bones		
Artificial valve		
Cancer		
Congenital heart defect		
Diabetes		
Drug Abuse		
Epilepsy		
Fainting spells		
Fibromyalgia		
Hemophilia		
Hepatitis		
Heart attack		
Heart surgery		

Medical problem	Yes	No
Herpes		
High blood pressure		
HIV/AIDS		
Hospitalized for any reason		
Kidney problems		
Liver problems		
Pacemaker		
Psychiatric treatment		
Rheumatic fever		
Seizures		
Sickle cell disease		
Steroid therapy		
Stroke		
Thyroid disease		
Transplant surgery		
Ulcers		

Other medical problems not listed above: _____

Please list all the **medications** you are taking: _____

_____

Are you **allergic** to Aspirin, Clindamycin, Codeine, Flaygyl, Ibuprofen, Latex, Penicillin, Steroids, Other?

If so, please explain _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____ _____ _____

Patient's signature (Or guardian) Date Doctor's signature Date