Patient's Name: Today's Date_____/_____/_____

HEALTH HISTORY

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes:
Are you on a special diet?	☐ Yes	☐ No	If yes:
Do you use tobacco currently?	☐ Yes	☐ No	If yes:
Have you used tobacco in the past?	☐ Yes	☐ No	If yes:
Do you use any other controlled substances?	☐ Yes	☐ No	If yes:
Are you aware, or been told, that you snore?	☐ Yes	☐ No	If yes:
Have you ever had a sleep study?	☐ Yes	☐ No	If yes:
Have you ever been told to wear a CPAP?	☐ Yes	☐ No	If yes:

Women:

☐	Pregnant/Trying to get pregnant?	☐	Nursing?	☐	Taking oral contraceptives?

Are you allergic to any of the following?

☐Aspirin	☐Penicillin	☐Codeine	☐Acrylic
☐Metal	☐Latex	☐Sulfa Drugs	☐Local Anesthetics

Do you have any other known drug allergies? ☐ Yes ☐ No
If yes:

Do you have, or have you had, any of the following? (please check all that apply)

☐	AIDS/HIV Positive	☐	Cortisone Medicine	☐	Hemophilia	☐	Radiation Treatments
☐	Alzheimer's Disease	☐	Diabetes	☐	Hepatitis A	☐	Recent Weight Loss
☐	Anaphylaxis	☐	Drug Addiction	☐	Hepatitis B or C	☐	Renal Dialysis
☐	Anemia	☐	Easily Winded	☐	Herpes	☐	Rheumatic Fever
☐	Angina	☐	Emphysema	☐	High Blood Pressure	☐	Rheumatism
☐	Arthritis/Gout	☐	Epilepsy or Seizures	☐	High Cholesterol	☐	Scarlet Fever
☐	Artificial Heart Valve	☐	Excessive Bleeding	☐	Hives or Rash	☐	Shingles
☐	Artificial Joint	☐	Excessive Thirst	☐	Hypoglycemia	☐	Sickle Cell Disease
☐	Asthma	☐	Fainting Spells/Dizzy	☐	Irregular Heartbeat	☐	Sinus Trouble
☐	Blood Disease	☐	Frequent Coughs	☐	Kidney Problems	☐	Spina Bifida
☐	Blood Transfusion	☐	Frequent Diarrhea	☐	Leukemia	☐	Stomach/Intestinal Disease
☐	Breathing Problems	☐	Frequent Headaches	☐	Liver Disease	☐	Stroke
☐	Bruise Easily	☐	Genital Herpes	☐	Low Blood Pressure	☐	Swelling of Limbs
☐	Cancer	☐	Glaucoma	☐	Lung Disease	☐	Thyroid Disease
☐	Chemotherapy	☐	Hay Fever	☐	Mitral Valve Prolapse	☐	Tonsillitis
☐	Chest Pains	☐	Heart Attack/Failure	☐	Osteoporosis	☐	Tuberculosis
☐	Cold Sores/Fever Blisters	☐	Heart Murmur	☐	Pain in Jaw Joint	☐	Tumors or Growths
☐	Congenital Heart Disorder	☐	Heart Pacemaker	☐	Parathyroid Disease	☐	Ulcers
☐	Convulsions	☐	Heart Trouble/Disease	☐	Psychiatric Care	☐	Venereal Disease

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If yes: _____

_____

_____

Additional Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

X_____ Date:_____

Signature of Patient, Parent or Guardian

Dental SOLUTIONS