Sweet TOOTH DENTISTRY

Health History

Patient Name: _____ Date: _____

Please check the boxes of the following problems or conditions that you have or have had in the past:

__Rheumatic Fever	___ Thyroid Disease	____Seizure Disorder
__Heart Disease	___ Anemia	____ Kidney Disease
__ Heart Murmur (or MVP)	___ Asthma	____ Venereal Disease
__ High Blood Pressure	___ Diabetes	____ Bleeding Problems
__ Tuberculosis	___ Nursing	____ Cancer
__ Use Oral Contraceptives	___ Pregnant	____ HIV/AIDS
__ Artificial Joint/Heart Valve	___ Hepatitis _A _B _C	____ Eating Disorders
__ History of Endocarditis	___ Radiation Therapy: Head/Neck	____Depression/Anxiety

Other Conditions not listed: _____

Are you allergic to Latex, soy or egg products? _____

List any antibiotics or other drugs you are allergic to: _____

List all prescription medications you are presently taking: _____

Have you been hospitalized in the past five years: _yes _no Explain: _____

Family Physician: _____ Phone: _____

Have you ever been a drug or substance abuser: _____yes _____no

Do you smoke: _____yes _____no How much: _____

Is there anything that you would like to discuss with the Doctor in private?

_____

_____ _____

Patient/Guardian Signature **Date**

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