

**Personal Health Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you allergic to?

Latex  Dental Anesthetics  Penicillin  Erythromycin  Aspirin  Codeine  Sulfa  Metals

Other: \_\_\_\_\_

Do you use tobacco products?  Yes  NO  Cigarettes  Pipes  Chew  Dip  Daily  Seldom

Consume alcohol beverages?  Yes  NO  Daily  Seldom

**WOMEN:** Are you or do you think you might be pregnant?  Yes  NO Are you nursing?  Yes  NO

How would you rate your general health?  Excellent  Good  Fair  Poor

Have you had or do you currently have any of the following? List medication(s) or drug(s) taken for the condition.

- Yes  NO Heart Disease Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Heart Attack Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Chest Pains Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Stroke Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Rheumatic Fever Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Mitral Valve Prolapse Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Congenital Heart Disease Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Artificial Heart Valves Placed when \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Heart Pacemaker Placed when \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO High Blood Pressure Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Blood Transfusion When \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Epilepsy or Seizures Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Drug Addiction/Alcoholism Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Implants Type \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Kidney Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Thyroid Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Liver Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Mental Health Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Bleeding Problems or Hemophilia \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Genetic Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Hormonal Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Lung Problems Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Venereal Disease Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO A.I.D.S. / H.I.V. Positive Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Cortisone/Steroids Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Persistent Cough Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Artificial Joints Type \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Asthma Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Cancer Type \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Sinus Trouble Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Allergies Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Arthritis Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Hepatitis Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Diabetes  Yes Type II Medication \_\_\_\_\_ Notes \_\_\_\_\_
- Yes  NO Tuberculosis Medication \_\_\_\_\_ Notes \_\_\_\_\_

List any medications/vitamins/supplements not listed above: \_\_\_\_\_

Name of Your Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Are you currently under the care of a physician?  Yes  NO If yes, for what reason? \_\_\_\_\_

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Have you been hospitalized within the past 12 months?  Yes  NO If yes, for what reason?

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**Please read the paragraph below and sign. Your signature will indicate that you have read the paragraph and agree to these statements.**

*The information given above regarding the patient medical and dental histories is accurate and complete to the best of my knowledge. I will not hold the dentist or her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any changes occur, it is my responsibility to inform the dentist and her staff.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Below
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I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_