

HEALTH HISTORY

PATIENT INFORMATION

Name: _____ Age: _____ Date: _____

Today's Problem _____

MEDICAL INFORMATION

PLEASE ANSWER EACH QUESTION. IT IS VERY IMPORTANT IN YOUR TREATMENT BEFORE AND AFTER SURGERY.

1. List ALL Drug Allergies: _____

2. List any medications you are currently taking including herbal, naturopathic or over the counter: _____

3. List prior operations: (none) _____

4. Have you ever had any bleeding requiring special treatment and/or family history of this? If so, please explain. _____

5. **Circle** if you have had any of the following problems:

heart disease - rheumatic fever - heart murmur - heart attack - high blood pressure - stroke - pneumonia - bronchitis - asthma - hay fever - chronic cough - tuberculosis - emphysema - hepatitis - jaundice - AIDS, HIV, ARC - abnormal bleeding - diabetes - thyroid disease - sinusitis - ulcers - epilepsy - seizures - arthritis - glaucoma - kidney disease - venereal disease - anemia - bleeding problems - fibromyalgia

- a) Do you have chest pain requiring nitroglycerin? Yes No
- b) Do you have artificial or replacement valves or a Pacemaker? Yes No
- c) Do you ever get short of breath while carrying out normal activities? Yes No
- d) Have you had a recent weight change? Yes No
- e) Women: Are you pregnant? Yes No
- f) Are you normally given antibiotics before a dental procedure? Yes No
- g) Any recreational drug use or addiction? Yes No
- h) Do you smoke or chew tobacco products? How much? _____ Yes No
- i) Have you ever been treated for a Psychiatric problem or been on antidepressants? Yes No
- j) Do you have any medical or religious reasons why you should not receive blood products? Yes No
- k) Have you had any surgery or x-ray treatment for a tumor, growth or other condition? Yes No

CHILD HISTORY

6. Complete this portion if the patient is a child.

- a) Was your child born prematurely? Yes No How premature? _____
- b) Has your child had their immunizations for their age? Yes No
- c) Is your child growing normally? Yes No

Signature _____

Relation to Patient _____