Health History

Please complete the following confidential information. Your complete answers will assist us in treating you with consideration for your special needs.

Family Physician: _____

Date of last visit: _____ Reason for this visit: _____

1. Do you have a current medical problem or condition? Condition: _____ □ YES □ NO

   If yes, physician's name: _____ Phone: _____

2. Have you been hospitalized or have you had a serious illness within the last 5 years? □ YES □ NO

   If so, list illness or operations/dates: _____

3. Do you have heart trouble or any form of cardiovascular disease (please √ known conditions)? □ YES □ NO

□ Heart Surgery (Date_____)	□ Angina/chest pains (Frequency _____)	□ High Blood Pressure
□ Prosthetic Heart Valve (Date_____)	□ Heart Attack (Date _____)	□ Stroke (Date _____)
□ Bypass (Date_____)	□ Heart Murmur	□ Low Blood Pressure
□ Angioplasty (Date_____)	□ Mitral Valve Defect	□ Atheorscierosis
□ Pacemaker (Date_____)	□ Congenital heart defect	□ Other _____

4. Please list any medications and dosages you currently take or have taken in the last year: _____

   _____

5. Do you or have you ever had any of the following (please √ known conditions)? □ YES □ NO

□ Hepatitis (Date_____ Type ____)	□ Tuberculosis (Date _____)	□ Epilepsy or seizures
□ Liver Disease or Jaundice	□ Persistent Cough	□ Fainting or Dizzy Spells
□ Kidney Disease	□ Emphysema/Asthma	□ Arthritis
□ Diabetes	□ Chronic Head, Neck, or Back Pain	□ Sinus Trouble/Hay Fever
□ Hyper/Hypothyroidism	□ Allergies or Hives _____	□ Glaucoma
□ HIV	□ Artificial Joint, Limb, or Implant (Hip, Knee)	□ Nervousness
□ Hypo/Hyperglycemia	□ AIDS or ARC	□ Psychiatric Treatment
□ Stomach or Intestinal Ulcers	□ Herpes	□ Alcoholism
□ Prolonged Bleeding	□ Venereal Disease (Syphilis, Gonorrhea)	□ Drug Addiction
□ Anemia	□ Cancer _____	□ Special Diet
□ Sickle Cell Disease	□ Chemotherapy (Date _____)	□ Cosmetic Surgery (Face, Neck)
□ Blood Transfusion	□ Cortisone Medicine	□ Wearing Contact Lenses
□ Bruise Easily	□ Limitation of Activity (_____)	□ Other _____

6. Have you ever taken prophylactic antibiotics prior to dental treatment? □ YES □ NO

7. Are you allergic to or have you had any unusual reaction to any drugs or medicines? □ YES □ NO

   If YES, please list: _____

8. Are you allergic to or have you ever reacted adversely to latex? □ YES □ NO

9. Have you had surgery, radiation or other treatments for a tumor or growth to head or neck? □ YES □ NO

10. For Women: Are you pregnant? If so, what month? _____ □ YES □ NO
    Are you taking birth control pills? □ YES □ NO

The above medical information is correct to the best of my knowledge. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment by Dr. Major and office staff. I understand that the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered.

Patients Signature _____Date _____

Parent/Responsible Party _____Relationship _____