



HEALTH HISTORY

| DOB:

Summary

Medical Conditions	none listed
Allergies	none listed
Medications	none listed

General Health Information

Are you currently under the care of a physician? (Physician's Name)	
Physician phone number	
Date of last physical exam	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
Do you use alcohol? (If yes, how often?)	
Do you use or have you ever used tobacco? (If yes, how often?)	
Have you ever had an allergic reaction? (If yes, what to?)	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer? (If so, what type?)	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / osteopenia?	
Type I or Type II diabetes?	

Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Any other medical condition we should know of?	
Recreational drug use? (If so, what and how often?)	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature:

Date: