

HEALTH HISTORY

Physician's Name _____

Are you currently being treated by a physician? Yes _____ No _____

Any recent illness or surgeries? _____

Allergic to any medication? _____

Taking any medication? _____

Allergic to metals, latex, or other known allergies? _____

Ever taken the diet drugs Pondimin, Phen-Phen or Redux? _____

Ever needed antibiotic pre-medication before receiving dental treatment? Yes / No

Do you have migraine headaches? Yes/ No

Any History of:

Heart Trouble, Murmur or Valvular Disorder	Yes _____ No _____
High Blood Pressure	Yes _____ No _____
Diabetes	Yes _____ No _____
Rheumatic Fever	Yes _____ No _____
Kidney, Liver Disorder or Jaundice	Yes _____ No _____
Eye Disorders	Yes _____ No _____
Allergy to local Anesthetic	Yes _____ No _____
Emotional Stress	Yes _____ No _____
Prolonged Bleeding	Yes _____ No _____
Asthma or Upper Respiratory Conditions	Yes _____ No _____
Epilepsy	Yes _____ No _____
Arthritis	Yes _____ No _____
Hepatitis	Yes _____ No _____
AIDS or Positive HIV	Yes _____ No _____
Radiation Treatments	Yes _____ No _____
Malignancies, Tumors or Cancer	Yes _____ No _____
Anemia or Blood Disorders	Yes _____ No _____
Venereal Disease or Herpes	Yes _____ No _____
Currently Pregnant	Yes _____ No _____
Smoking/Smokeless Tobacco	Yes _____ No _____
Artificial Limbs, Transplants, Or Joint Replacements	Yes _____ No _____

I understand that I am financially responsible for all treatment fees, regardless of my insurance benefits.

* _____
Patient or Parent Signature

* _____
Date