Patient Name _____ Date _____

Health History

Medical Doctor's Name _____

Clinic Name and Phone# _____

Pharmacy Name _____

Phone # _____

Place a mark on yes or no to indicate if you have the following:

AIDS/HIV	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hepatitis, type _____	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Herpes		
Artificial Heart Valve	☐ Yes	☐ No	cold sores	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	canker sores	☐ Yes	☐ No
date _____			High Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain / TMJ/TMD	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Bleeding abnormally,			Liver Disease	☐ Yes	☐ No
with extractions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Bone Builders			Radiation treatment	☐ Yes	☐ No
ex: Fosamax	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes, type _____	☐ Yes	☐ No	Swollen feet or ankles	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Tobacco Usage		
Females: pregnant	☐ Yes	☐ No	smoking	☐ Yes	☐ No
birth control pill	☐ Yes	☐ No	chewing	☐ Yes	☐ No

MEDICATIONS

List any medicines you are taking:

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Metals
- ☐ Other: _____
- ☐ Penicillin
- ☐ Sulfa
- ☐ Local Anesthetic (Novocaine, Etc.)

_____

_____

_____