HEALTH HISTORY

Name: ______________________________

(Circle One)

1. Are you having pain or experiencing discomfort at this time? .... YES NO
2. Do you feel nervous about having dental treatment or have you had a bad experience in a dental office? .... YES NO
3. Have you been a patient in the hospital during the past two years? .... YES NO
4. Have been under the care of a medical doctor during the past two years? .... YES NO
   Physician's Name: ______________________________ Phone: ______________
5. Have you taken any medicine or drugs during the past two years? .... YES NO
   Are you now taking any prescription or over the counter medication? .... YES NO
   If yes, please list: ______________________________

6. Are you allergic or have you reacted adversely to any of the following? ....

Latex	Other Antibiotics	Nitrous Oxide	Local Anesthetics (Novocaine/Xylocaine)
Sulfa	Aspirin	Valium	Sleeping Pills (Nembutal/Seconal)
Amoxicillin/Penicillin	Codeine	Scopolamine	
Tetracycline	Pain Medicine		

   If you answered yes to any of the above, please list: ______________________________
7. Are you aware of being allergic to any other medications or substance? .... YES NO
   If yes, please list: ______________________________
8. Circle any of the following which you have had or have at present:

Artificial Joints (Hip, Knee)	Emphysema	Cancer	Hepatitis A
Artificial Heart Valve	Cough	Chemotherapy	Hepatitis B
Heart Murmur	Sinus Trouble	Radiation Treatment	Hepatitis C
Mitro-Valve Prolapse	Asthma	Arthritis	HIV/AIDS
Heart Pacemaker	Tuberculosis (TB)	Rheumatism	Liver Disease
Rheumatic Fever	High Blood Pressure	Anemia	Yellow Jaundice
Heart Failure	Diabetes	Cortisone Medicine	Kidney Trouble
Heart Disease/Attack	Auto Immune Disorders		Ulcers
Angina Pectoris	Hay Fever	Hemophilia	Acid Reflux
Congenital Heart Lesions	Thyroid Disease	Blood Transfusion	Venereal Disease
Heart Surgery	Cold Sores	Epilepsy/Seizures	Nervousness
Scarlet Fever	Fever Blisters	Fainting/Dizzy Spells	Drug Addiction
Stroke	Glaucoma	Psychiatric Treatment	Bruise Easily

   Has a surgeon asked you to PREMEDICATE for any of the above? .... YES NO
9. Do you have any disease, condition, or problem not listed? .... YES NO
   If yes, please explain: ______________________________
10. Do you or have you ever had pain in your jaw joints? .... YES NO
11. Have you ever been told that you snore or been diagnosed with sleep apnea? .... YES NO
    Do you ever wake up short of breath or tired? .... YES NO
12. Do you use more than 2 pillows to sleep? .... YES NO
13. Do you ever experience shortness of breath, chest pain, or become tired during normal activities? .... YES NO
14. Do your ankles swell during the day? .... YES NO
15. Have you lost/gained more than 10 pounds in the past year? .... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what trimester? ______ Are you taking birth control pills? ☐ Yes ☐ No

CONSENT: THE ABOVE INFORMATION IS TRUE

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connections with (Patient)____________________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note. I also agree that in case credit is extended, my credit can be checked with the Credit Bureau of Idaho.

Patient, Parent or Responsible Party: ______________________________ ______________
Signature Date

Doctor: ______________________________ ______________
Signature Date