Health History

Print Patient's name: _____

Physician's name: _____ Phone #: _____

List any medications you are currently taking: _____

List any allergies to any medication or substance: _____

Have you been under the care of a medical doctor during the past two years? y/n if so for what?

_____

Have you seen an ENT? y/n Have you seen a neurologist? y/n Have you had braces? y/n

Name: _____ Name: _____ Name: _____

***Please circle yes or no to each item*:**

Heart concerns y/n **Congenital Heart Disease** y/n **Heart murmur** y/n **High blood pressure** y/n

Mitral valve prolapse y/n **artificial heart valve** y/n **Pacemaker** y/n **Stroke** y/n

Asthma y/n **Liver disease/jaundice** y/n **Latex allergy** y/n **artificial joints** y/n **Kidney stones** y/n

Kidney trouble y/n **Radiation/chemotherapy** y/n **Epilepsy//seizures** y/n **Diabetes** y/n

Hepatitis y/n Type: _____ **Aids/Hiv** y/n **STD's** y/n Type: _____ **Headaches** y/n

Jaw pain y/n **Jaw popping** y/n **Dizziness** y/n **Grinding** y/n **Ringing ears** y/n **Congested ears** y/n
Loose teeth y/n **Limited opening** y/n **Neck ache** y/n **Clenching** y/n **Posture problems** y/n
Facial pain y/n **Sensitive teeth** y/n **Bell 's palsy** y/n **Insomnia** y/n **Pregnant** ? y/n

Difficulty chewing y/n **Difficulty swallowing** y/n **Trigeminal Neuralgia** y/n **Sickle cell disease** y/n
Neurological disorders y/n **Tingling in arms/fingers** y/n **Do your gums bleed**? y/n

Does food pack/catch between your teeth? y/n **Does your breath concern you**? y/n

Do you have or have you had any disease, condition or problem not listed? _____

Signature: _____ Date: _____

Dentist Signature: _____ Date:_____