HEALTH HISTORY

The following information is very important and will aid us in caring for your dental needs.

CIRCLE

1. Are you having pain or discomfort at this time ..... YES NO
2. Have you ever fainted in a dental office? ..... YES NO
3. Have you had a serious accident or head injury ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
   For what reason? _____
5. Do you smoke or chew tobacco ..... YES NO
6. Have you been under the care of a medical doctor during the past two years? ..... YES NO
7. Name of Physician _____
   Address _____ Phone _____
8. Have you taken any prescription medication or drugs during the past two years? ..... YES NO
9. Are you now taking any medication, drugs or pills? ..... YES NO
   If yes, please list: _____
10. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO
    If yes, please list: _____
11. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart Failure	YES NO	Cough	YES NO	Hepatitis B	YES NO
Heart Disease or Attack	YES NO	Tuberculosis (TB)	YES NO	Hepatitis (other)	YES NO
Angina Pectoris	YES NO	Asthma	YES NO	Liver Disease	YES NO
High Blood Pressure	YES NO	Hay Fever	YES NO	Yellow Jaundice	YES NO
Mitral Valve Prolapse	YES NO	Sinus Trouble	YES NO	Blood Transfusion	YES NO
Heart Murmur	YES NO	Allergies or Hives	YES NO	Alcohol or Drug Addiction	YES NO
Rheumatic Fever	YES NO	Diabetes	YES NO	Hemophilia	YES NO
Congenital Heart Lesions	YES NO	Thyroid Disease	YES NO	Venereal Disease	
Scarlet Fever	YES NO	RadiationTherapy	YES NO	(Syphilis, Gonorrhea)	YES NO
Artificial Heart Valve	YES NO	Chemotherapy (Cancer, Leukemia)	YES NO	Cold Sores / Fever Blisters	YES NO
Heart Pacemaker	YES NO	Arthritis	YES NO	Epilepsy or Seizures	YES NO
Heart Surgery	YES NO	Rheumatism	YES NO	Fainting or Dizzy Spells	YES NO
Artificial Joints (Hip, Knee)	YES NO	Cortisone Medicine	YES NO	Nervousness	YES NO
Anemia	YES NO	Anticoagulant Medicine	YES NO	Depression	YES NO
Stroke	YES NO	Glaucoma	YES NO	Psychiatric Treatment	YES NO
Kidney Trouble	YES NO	Pain in Jaw Joints	YES NO	Sickle Cell Disease	YES NO
Ulcers	YES NO	A.I.D.S.	YES NO	Bruise Easily	YES NO
Cosmetic Surgery	YES NO	HIV Positive	YES NO	Allergies to Jewelry	YES NO
Emphysema	YES NO	Hepatitis A (infectious)	YES NO		

12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
13. Do you snore? ..... YES NO
14. Have you been diagnosed with sleep apnea? ..... YES NO
15. Do you use more than 2 pillows to sleep? ..... YES NO
16. Have you lost or gained more than 10 lbs. in the past year? ... YES NO
17. Do you ever wake up from sleep short of breath? ..... YES NO
18. Are you on a special diet? ..... YES NO
19. Do you bleed excessively when cut? ..... YES NO
20. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
21. Do you have any disease, condition or problem not listed? ..... YES NO
    Please describe _____
    _____
22. Is there any other information concerning your health that we should know about ..... YES NO
    Please describe _____
    _____

Are you pregnant? ❑ YES ❑ NO If yes, what month? _____ Are you taking birth control pills? ❑ YES ❑ NO
Are you nursing? ❑ YES ❑ NO

Reviewed by _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my belief. I hereby authorize White Family Dental and their staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____