HEALTH HISTORY FORM

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or the medication you may be taking, could have a significant interrelationship with the dentistry you will be receiving. Please answer the following questions carefully. Thank you!

Health Conditions Relating to Dental Treatment

HEALTH CONDITIONS

1. Do you have or have you ever had any of the following conditions?

a.	Rheumatic Fever	☐ Yes	☐ No	j.	Tuberculosis	☐ Yes	☐ No
b.	Hepatitis	☐ Yes	☐ No	k.	Asthma	☐ Yes	☐ No
c.	Heart Murmur	☐ Yes	☐ No	l.	A.I.D.S./A.R.C.	☐ Yes	☐ No
d.	Heart Attack	☐ Yes	☐ No	m.	Kidney or Liver Trouble	☐ Yes	☐ No
e.	High Blood Pressure	☐ Yes	☐ No	n.	Thyroid Disease	☐ Yes	☐ No
f.	Stroke	☐ Yes	☐ No	o.	Prolonged Bleeding	☐ Yes	☐ No
g.	Diabetes	☐ Yes	☐ No	p.	Cancer	☐ Yes	☐ No
h.	Venereal Disease	☐ Yes	☐ No	q.	Frequent headaches/migraines	☐ Yes	☐ No
i.	Herpes	☐ Yes	☐ No	r.	Epilepsy	☐ Yes	☐ No

2. Do you have an artificial heart valve? ☐ Yes ☐ No
3. Do you have a cardiac pacemaker? ☐ Yes ☐ No
4. Do you have any artificial joints? ☐ Yes ☐ No
5. Have you been hospitalized within the last five years? ☐ Yes ☐ No
6. If you are female, are you pregnant? ☐ Yes ☐ No
7. Are you allergic to anything other than drugs, such as plastics or nickel? ☐ Yes ☐ No
8. Do you have any disease, condition or handicap not listed above? ☐ Yes ☐ No
   If so, please explain: _____
9. Name of Physician and location: _____
10. Person to contact in case of emergency: _____ Phone: _____

DRUGS & MEDICATION

1. Are you taking any over-the-counter drugs or prescription medications? ☐ Yes ☐ No
   If so, please complete below:

Name of Drug or Medication	The condition it is taken for:
_____	_____
_____	_____

2. Have you had any allergies or adverse side effects to any drugs or medications such as novocaine, xylocaine, aspirin, codeine, penicillin, fluoride, etc.? ☐ Yes ☐ No
   If so, please complete below:

Name of Medication	The reaction you experienced:
_____	_____
_____	_____

DENTAL INFORMATION

1. Do you have or have you ever had any of the following conditions?

a.	Bleeding gums	☐ Yes	☐ No	d.	Loose teeth	☐ Yes	☐ No
b.	Tooth grinding	☐ Yes	☐ No	e.	Injury to face or jaw	☐ Yes	☐ No
c.	Tooth sensitivity	☐ Yes	☐ No	f.	Tendency to gag	☐ Yes	☐ No

2. Have you been advised to see an Orthodontist (straightens teeth)? ☐ Yes ☐ No
3. Have you been advised to see a Periodontist (specialist in gums and bone)? ☐ Yes ☐ No
4. Do you prefer Nitrous Oxide (laughing gas) when you are worked on? ☐ Yes ☐ No

For your benefit, a thorough examination (including x-rays) is necessary before an intelligent and accurate diagnosis can be reached and proper treatment rendered. I authorize Carol J. McCutcheon, D.D.S. and/or her staff to perform whatever services and use whatever anesthetics their professional judgment deems necessary for proper treatment in my dental care. If there are any changes in my medical history, I will inform the dentist or hygienist.

_____ _____

Signature of Patient (or Guardian) Date