Advanced Dental Artistry

Health History

Thank you for taking the time to fill out this important form accurately. At times, medication or procedures used in dentistry can affect other medical situations. Your responses are appreciated and are completely confidential.

Name:_____ Age: _____

I. Please Circle the Appropriate Answer:

1. Is your general health good? Yes No
2. Have you been hospitalized or had a serious illness in the last three years? Yes No

   Why? _____
3. What was the date of your last medical exam / Doctor's Name?
4. Do you take medication (including aspirin)? Yes No

   Please list medications: _____

   _____

II. Do you have, or have you had, any of the following?

High Blood Pressure	Yes	No	Allergies to Food/Medication	Yes	No
Heart Murmur	Yes	No	Artificial Joint	Yes	No
Rheumatic Fever	Yes	No	Prosthetic Heart Valve	Yes	No
Heart Defects	Yes	No	Heart Disease	Yes	No
Chest Pain	Yes	No	Heart Attack	Yes	No
HIV/AIDS	Yes	No	Seizures	Yes	No
Headaches	Yes	No	Dry Mouth	Yes	No
Stroke	Yes	No	Pacemaker	Yes	No
Sinus Problems	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Lung Disease/COPD	Yes	No
Tuberculosis	Yes	No	Stomach Ulcers	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Chemotherapy	Yes	No	Radiation Treatment	Yes	No
Bleeding Problems	Yes	No	Hepatitis/Liver Disease	Yes	No
Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Psychiatric Care	Yes	No	Eye Disease/Glaucoma	Yes	No
Cigarettes or Tobacco	Yes	No	Fainting Episodes	Yes	No
Drink Alcohol	Yes	No	Recreational Drug Use	Yes	No

III. Women Only:

Are you pregnant or nursing? Yes No Unsure

Are you taking birth control pills? Yes No

Women taking birth control medications should be aware that antibiotics can cause the birth control medications to be ineffective possibly resulting in pregnancy.

I understand that the information I have given today is correct to the best of my knowledge.

Signature: _____ Date: _____