Health History

Name Printed:_____

Are you **allergic** to any medications, latex, or metals? _____ If yes, which ones?

_____

Are you currently taking **any daily medications?** If yes, what medications are you taking and for what reasons?

_____

Do you take any blood thinners or bisphosphonate drugs? _____

Do you have any artificial joints? What joint? _____ Date of surgery_____

Are you having any problems with your joint since its replacement?

_____

Have you ever been told by a health care provider that you need antibiotic pre-medication before dental treatment? Yes or No

If yes, for what reason? _____

Is your immune system suppressed? _____

Are you taking any steroids? _____

Are you pregnant, nursing, or taking birth control pills? _____

Do you have or have you ever had any of the following medical conditions? Please circle if **YES**

Seizures Diabetes Cancer Chemo Therapy

Heart Defect/Murmur Heart Disease/Surgery Organ Transplant Radiation Therapy

Artificial Heart Valve Vascular Stents/Port Rheumatism AIDS/HIV

Sexually Transmitted Disease CF Shunts Lupus Stroke

High/Low Blood Pressure Kidney Trouble Stomach Ulcers Pacemaker

Hepatitis Jaundice Tuberculosis Asthma

Epilepsy Lung Problems Anemia Sinus Trouble

Health History

Leukemia Fainting Spells Drug Addiction Blood Transfusion

Glaucoma Abnormal Bleeding Thyroid Problems

If you answered **“yes”** to any of the above conditions/disease, **please explain:**

_____

Have you been hospitalized in the past year? _____

Physicians Name_____ Phone:_____

To the best of my knowledge, the above questions have been accurately answered.

_____ _____

Signature Date