| Original Date: |
|---|
| **Dates Revised:** |
| 1st Update |
| 2nd Update |
| 3rd Update |

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

| PERSONAL HEALTH HISTORY | | |
|---|---|---|
| Do you smoke or use Tobacco | ☐ Yes | ☐ No |
| Are you required to PRE MEDICATE prior to dental appointment | ☐ Yes | ☐ No |
| If yes, list medication | | |
| Are you taking any medications? If so please List | ☐ Yes | ☐ No |
| | | |
| Are you currently under a physicians care? | ☐ Yes | ☐ No |
| Physicians Name: Physicians Telephone: | | |
| Have you ever been hospitalized? If so date | ☐ Yes | ☐ No |

| WOMEN ONLY | | |
|---|---|---|
| Are you pregnant or breastfeeding? | ☐ Yes | ☐ No |

Check if you have, or have had, any symptoms or allergies reactions to the list below if so please check.

| | | |
|---|---|---|
| ☐ Abnormal Bleeding | ☐ Fever Blisters | ☐ Mitral Valve Prolapse |
| ☐ Alcohol Abuse | ☐ Hay Fever | ☐ Psychiatric Problems |
| ☐ Arthritis | ☐ Headaches | ☐ Radiation Treatment |
| ☐ Artificial Bones/Joints | ☐ Heart Attack | ☐ Rheumatic Fever |
| ☐ Artificial Valves | ☐ Heart Murmur | ☐ Seizures |
| ☐ Blood Transfusion | ☐ Heart Surgery | ☐ Sinus Problems |
| ☐ Cancer | ☐ Hepatitis | ☐ Steroid Therapy |
| ☐ Chemotherapy | ☐ Herpes | ☐ Tonsillitis |
| ☐ Congenital Heart Defect | ☐ High Blood Pressure | ☐ Tuberculosis(TB) |
| ☐ Diabetes | ☐ HIV+, AIDS | ☐ Ulcers |
| ☐ Difficulty Breathing | ☐ Kidney Disease | ☐ Venereal Disease |
| ☐ Drug Abuse | ☐ Liver Disease | ☐ Other |
| ☐ Fainting Spells | ☐ Low Blood Pressure | ☐ Sulfa, Asprin, Codine, Latex, Penn |