HEALTH HISTORY RECORD

1. Are you now in good health? …… Yes No

2. Are you now or have you been under the care of a physician during the past 2 years? ……... Yes No
   Date of last physical examination: _____

3. Have you ever been a patient in a hospital? ……. Yes No
   Reason: _____ Date: _____
   _____ _____
   _____ _____
   _____ _____

4. Are you now or have you taken any drugs or medicines, including herbal medications or homopathic remedies, in the past year including medications on a daily basis ie. aspirin, birth control, Fen-Phen, Redux, etc.? … Yes No
   If so, please list : _____
   _____

5. Are you sensitive or allergic to any drugs/medications, foods or materials (i.e. penicillin, latex)? Yes No
   If so, please list: _____
   _____

6. Have you ever had any serious illnesses or conditions such as :

a) heart trouble/arrhythmia's ……	Yes No	k) venereal disease …… .	Yes No
b) high or low blood pressure …….	Yes No	l) diabetes ……	Yes No
d) tuberculosis ……	Yes No	n) hepatitis ……...	Yes No
e) kidney, liver or lung disease……	Yes No	o) heart murmur ……..	Yes No
f) arthritis ……	Yes No	p) emphysema …….	Yes No
g) rheumatic fever/scarlet fever……...	Yes No	q) severe/frequent headaches...	Yes No
h) asthma ……..…	Yes No	r) sinus trouble ……...	Yes No
i) epilepsy ……	Yes No	s) HIV/aids ……	Yes No

   j) other (please indicate) _____

7. Are you subject to any nervous disorders, fainting or dizziness?……. Yes No
8. Are you subject to excessive bleeding? ……. Yes No
9. Have you ever had psychiatric treatment?…….. Yes No
10. Do you have any difficulty in opening you mouth wide? ……. Yes No
11. Have you ever had any injury to your face or jaws? ……. Yes No
12. Do you have or have you ever been treated for TMJ (Temporomandibular Joint Disorder) …. Yes No
13. Have you ever had any difficulty with the use of local anesthetic ("Novocain") ……. Yes No
14. Do you have any numbness or tingling sensation in any part of your body? …… Yes No
15. Have you ever received radiation or surgical treatment for tumor, growth or other conditions about your head, mouth, lips?…….. Yes No
16. Women: Are you pregnant? Yes No How many months? _____
17. Do you wear contact lenses? ……. Yes No
18. Have you had anything to eat or drink in the last 6 hours? …… Yes No
    List: _____ At what time? _____ AM PM
19. Since we last saw you, has anything changed in your health history?…… Yes No
    Changes: _____
    _____

I confirm as true the above health history information.

Signature: _____ Date: _____

******Parent or guardian signature if patient is under the age of 18

Updated signature: _____ Date: _____