B.P. ___________
Pulse ___________

PATIENT NAME ______________________
DATE ______________________

HEALTH HISTORY	**YES**	**NO**
1. Is your general health good?	______	______
2. Are you under a physician's care for any medical condition? If yes, please explain: ______________________	______	______
3. Surgeries? If yes, please list: ______________________	______	______
4. Are you taking any medication regularly? If yes, what? ______________________	______	______
5. Do you heal normally after a cut?	______	______
6. Have you ever fainted?	______	______
7. Have your ever had an unusual or allergic reaction to any drug or local anesethetic? Please explain: ______________________	______	______
8. (Female) Are your pregnant or do you think you may be pregnant? Due Date ___________	______	______
9. Do you use tobacco in any form? How often? ______________________	______	______

10. Do you have or have you ever had any of the following:

	Yes	No
Rheumatic Fever	❑	❑
Heart murmur	❑	❑
Heart attack/Stroke	❑	❑
High blood pressure	❑	❑
Artificial heart valve/ Prolapsed heart valve	❑	❑
HIV Aids	❑	❑
Artificial joint (Screws, Pins, Plates or Rods)	❑	❑
Pacemaker	❑	❑
Heart surgery Type: ______________	❑	❑

	Yes	No
Hepatitis Type: ______________	❑	❑
Ulcers	❑	❑
Colitis	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
Liver Disease	❑	❑
Head and neck radiation	❑	❑
Any other conditions: ______________________	❑	❑

	YES	**NO**
11. Have you been advised to take antibiotics before dental cleanings?	______	______
12. Does seeing a dentist make you nervous?	______	______
13. Have your ever had any unfavorable dental experiences? If yes, please explain: ______________________	______	______
14. Has any dentist had difficulty getting your teeth numb?	______	______

______________________ Signature

______________ Date