HOWELL FAMILY DENTIST PATIENT HEALTH HISTORY (Please complete sections 1-6)

SECTION 1

		Yes	No
1.	Are you in good health?	☐	☐
2.	Are you under a physician's care?	☐	☐
3.	Are you subject to prolonged bleeding?	☐	☐
4.	Have you ever had chemotherapy/radiation?	☐	☐
5.	Have you had joint replacement in the last 2 years?	☐	☐
6.	Have you been instructed to take a premed/antibiotic prior to dental treatment due to a heart condition or hip/joint replacement?	☐	☐
7.	Do you have pain or clicking in your jaws/TMJ?	☐	☐
8.	Have you ever been treated for TMJ?	☐	☐

		Yes	No
9.	Have you ever had major surgery?	☐	☐
	List of procedure(s) performed.		
	_____		
	_____		
	_____		
10.	Have you been hospitalized in the last five years?	☐	☐
	List when and the reason or condition.		
	_____		
	_____		
	_____		
11.	**Women Only:**		
	Are you pregnant or think you may be pregnant?	☐	☐
	What month? _____		
	Are you taking birth control?	☐	☐

SECTION 2

	Yes	No
Cancer	☐	☐
Heart condition (pacemaker, angina, etc.)	☐	☐
Heart attack (coronary)	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Hepatitis or liver disease	☐	☐
High blood pressure	☐	☐
Kidney problems	☐	☐
Ulcers	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Respiratory or lung disease	☐	☐
Osteoporosis	☐	☐
Dental anxiety	☐	☐

	Yes	No
Anemia	☐	☐
Epilepsy	☐	☐
Neurological disorders	☐	☐
Glaucoma	☐	☐
Tuberculosis	☐	☐
Blood disorders	☐	☐
HIV positive or AIDS	☐	☐
Sexually transmitted disease	☐	☐
Herpes (oral-cold sores)	☐	☐
Fainting spells	☐	☐
Medical marijuana	☐	☐

Other health problems-please list below:

SECTION 3 Allergies

	Yes	No
Amoxicillin	☐	☐
Penicillin	☐	☐
Dental anesthetic	☐	☐
Novacaine	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Nitrous oxide	☐	☐
Latex/rubber products	☐	☐
Motrin	☐	☐
Anti-inflammatory	☐	☐
Narcotics	☐	☐

Please list any other allergies:

SECTION 4

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. INCLUDE NON-PRESCRIPTION DRUGS (I.E. VITAMINS, HERBAL)

SECTION 5

Medical Doctor's Name:_____

Medical Doctor's Phone Number:_____

SECTION 6

I acknowledge the above health information to be correct and understand any omissions may complicate my care.

Print Name:_____ Date:_____

Patient Signature:_____ Date:_____

Business Staff _____

Clinical Staff _____

Doctor _____