WOODBURY DENTAL *Care*

Health History

First & Last Name: _____

Yes No Are you currently under a physician's care for a serious illness, condition or had major surgery?
If yes, explain: _____
Physician's Name: _____
Yes No Have you been told you need to take an antibiotic (premedication) prior to a dental appointment?
Yes No Are you currently taking any prescription and/or "over the counter supplements"?
List: _____
Yes No Have you taken any cortisone/steroid therapy during the past two years?
Yes No Are you allergic to or had problems with medications i.e. antibiotics, anesthetics or other meds?
List: _____
Yes No Do you have any other allergies?
List: _____
Yes No Are you sensitive to any metals, dyes or latex?
Yes No Have you received the Human Papilloma Virus Vaccine (HPV)?

What is the source of your drinking water? City ☐ Well ☐ Bottled ☐ Reverse Osmosis ☐

Women:

Yes No Are you pregnant? If yes, due date: _____
Yes No Are you nursing?
Yes No Are you taking oral contraceptives or HRT?

Do you have OR have you ever had any of the following:

Yes	No	Artificial Joint/Prosthesis/Implant	Yes	No	Blood Transfusion
Yes	No	Heart Valve Implant	Yes	No	Liver Disease
Yes	No	Mitral Valve Prolapse	Yes	No	Hepatitis A, B, or C
Yes	No	Heart Disease/ Attack /Murmur	Yes	No	Tuberculosis
Yes	No	Rheumatic Fever	Yes	No	AIDS/HIV Exposure
Yes	No	High/Low Blood Pressure	Yes	No	Venereal Disease/Herpes/ HPV
Yes	No	Pacemaker	Yes	No	Alcoholism/Chemical Dependency
Yes	No	Asthma	Yes	No	Radiation Therapy
Yes	No	Sinus Issues	Yes	No	Cancer/Tumor
Yes	No	Epilepsy/seizures	Yes	No	Chemotherapy
Yes	No	Fainting/Dizzy Spells	Yes	No	Malignant Hyperthermia
Yes	No	Psychiatric Treatment	Yes	No	Stomach Issues
Yes	No	Glaucoma	Yes	No	Ulcers
Yes	No	Diabetes/Hypoglycemia	Yes	No	Anxiety
Yes	No	Eating Disorder	Yes	No	Recent Weight Loss
Yes	No	Circulatory Issues	Yes	No	Sleep Apnea/Snoring
Yes	No	Excessive Bleeding From Cut/Injury	Yes	No	Arthritis/Rheumatism
Yes	No	Blood Diseases/Anemia/Leukemia	Yes	No	Stroke
Yes	No	Do you smoke or chew tobacco?	Yes	No	Enzyme Deficiency

Yes No Do you have any disease, condition or problem not listed?
List: _____

If you are unsure or have questions about any of the above conditions, please ask your dental provider during the appointment.

To the best of my knowledge, the above information is true.

Patient/Parent Signature: _____ Date: _____ DDS/RDH/DA Initials: _____