# WOODBURY DENTAL Care

**Health History**

**Patient Name:**_____

**Date of Birth:** _____

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 Are you currently taking any prescription and/or "over the counter supplements"?
*List:* _____
_____
_____

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 Have you been told you need to take an antibiotic (premedication) prior to a dental appointment?

Yes No Are you sensitive to any metals, dyes, or latex? *List:* _____

Yes No Have you received the Human Papilloma Virus Vaccine (HPV)?

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

***Do you have OR have you ever had any of the following (if yes, please give Month and/or Year):***

Yes No Irregular Blood Pressure
*if yes*, High or Low

Yes No Anxiety

Yes No Smoke, vape, or chew tobacco

Yes No Fainting / Dizzy Spells

Yes No Cancer / Tumor
*If yes,* Chemotherapy / Radiation Therapy

Yes No Artificial Joint / Prosthesis / Implant

Yes No Heart Valve Implant

Yes No Heart Disease / Attack / Murmur

Yes No Rheumatic Fever

Yes No Pacemaker

Yes No Asthma

Yes No Sinus Issues

Yes No Epilepsy / seizures

Yes No Stroke

Yes No Arthritis / Rheumatism

Yes No Glaucoma

Yes No Diabetes / Hypoglycemia

Yes No Eating Disorder

Yes No Circulatory Issues

Yes No Excessive Bleeding from cut / injury

Yes No Blood Disease / Anemia / Leukemia

Yes No Blood Transfusion

Yes No Liver Disease

Yes No Hepatitis A, B, or C

Yes No Tuberculosis

Yes No AIDS / HIV Exposure

Yes No Venereal Disease / Herpes / HPV

Yes No Alcoholism / Chemical Dependency

Yes No Malignant Hyperthermia

Yes No Stomach Issues / Ulcers

Yes No Enzyme Deficiency

Yes No Sleep Apnea / Snoring

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

**WOMEN**

Yes No Are you pregnant? *If yes, due date:* _____

Yes No Are you nursing?

Yes No Are you taking oral contraceptives or HRT?

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

**Signature of Patient / Parent** _____ **Date** _____

*To the best of my knowledge, the above information is true and accurate*