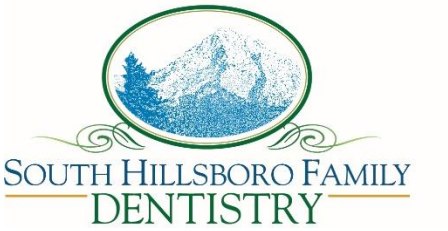
Health History

Name: _____ Birthdate: ___/___/_____



Have you been under the care of a physician in the last 5 years?
Yes _____ No _____

Reason for care: _____ Names
of Physicians currently providing your care:

1. _____Phone#: _____ 2. _____ Phone#: _____

Please circle yes or no to indicate whether you've experienced these conditions:

Anemia	No	Yes	Cancer	No	Yes
Epilepsy	No	Yes	Psychosis	No	Yes
Hepatitis, any form	No	Yes	Previous Biopsies	No	Yes
Asthma	No	Yes	Slow-Healing Mouth Sores	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Other Infections	No	Yes
Emphysema or other Respiratory Illness	No	Yes	Recurrent Illnesses	No	Yes
Abnormal Heart Condition	No	Yes	Joint Replacement	No	Yes
Kidney Disease	No	Yes	Liver Disease (including Jaundice)	No	Yes
Heart (surgery, Disease, Attack)	No	Yes	Abnormal Bleeding from a Cut	No	Yes
Venereal Disease	No	Yes	Unintentional Weight Gain/Loss	No	Yes
Diabetes	No	Yes	Latex Sensitivity	No	Yes
Hemophilia	No	Yes	Glaucoma	No	Yes
Hypertension (high blood Pressure)	No	Yes	Illegal Drug Use	No	Yes

Are you required to pre-medicate with an antibiotic before dental treatment? No Yes

Have you ever taken a bisphosphonate medication? No Yes
(usually to treat bone cancer or osteoporosis)

Are you currently pregnant or breastfeeding? No Yes

Are you currently taking any blood thinners? No Yes

Allergies to medications: No yes If yes, What? _____

Do you smoke? No Yes Notes:_____

Please list any medications you are taking:

_____

_____

1._____ 2._____ _____

3._____ 4._____ _____