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Health History Form

Patient Name _____ **Date** _____

Primary reason for this dental appointment: ☐ Exam ☐ Emergency ☐ Consultation

Initial Vital Signs: BP _____ Pulse _____ Respiration _____ Temperature _____

DENTAL HISTORY

Yes No (If "Yes", please give details)

☐ ☐ Do you have a specific dental problem? _____

☐ ☐ Would you be interested in learning about available options to improve your smile and appearance?

When was your last dental visit? _____ Reason for visit? _____

☐ ☐ Do you brush and floss on a routine basis? How often? _____

☐ ☐ Have you ever had a bad or unpleasant dental experience? Describe _____

_____

MEDICAL HISTORY

Medical Doctor's Name _____ **Phone No.** ( ) _____

Yes No (If "Yes", please give details)

☐ ☐ Are you in good health? _____

☐ ☐ Are you under a doctor's care now? Why? _____

☐ ☐ Have you been hospitalized in the last two years? Why? _____

☐ ☐ Are you allergic to any medication or substance? What? _____

☐ ☐ Are you pregnant? How many months? _____

☐ ☐ Do you take birth control pills? _____

WARNING! Antibiotics may alter the effectiveness of birth control pills.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Epilepsy/Seizures	☐	☐	Hepatitis B (serum)	☐	☐	Hemophilia
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Yellow Jaundice	☐	☐	Frequent Headaches
☐	☐	Rheumatic Fever	☐	☐	Cobalt Treatment	☐	☐	Drug Addiction	☐	☐	Allergies
☐	☐	Congenital Heart Disease	☐	☐	AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Herpes
☐	☐	Chemotherapy/Radiation	☐	☐	Glaucoma	☐	☐	Asthma	☐	☐	Venereal Disease
☐	☐	Psychiatric Care	☐	☐	Artificial Heart Valve	☐	☐	Stroke	☐	☐	Ulcers
☐	☐	Cortisone Medicine	☐	☐	Arthritis/Gout	☐	☐	Heart Pacemaker	☐	☐	Anemia
☐	☐	Heart Surgery	☐	☐	Blood Transfusion	☐	☐	Emphysema	☐	☐	Lung Disease
☐	☐	Nervousness	☐	☐	High Blood Pressure	☐	☐	Kidney Trouble	☐	☐	Tuberculosis
☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐	Liver Disease	☐	☐	Tumors/Growths
☐	☐	Blood Disease	☐	☐	Fainting/Dizziness	☐	☐	Hepatitis A (Infection)	☐	☐	Mitral Valve Prolapse
☐	☐	Sinus Trouble	☐	☐	Head Injuries	☐	☐	Artificial Joints/Hips	☐	☐	Jaw Pain

☐ ☐ Have you been advised by your physician to take Antibiotic Premedication before your dental appointments? If so, in what form?

_____

☐ ☐ Have you ever had any serious illness, not listed above? Describe _____

CONSENT

I hereby grant authority to Alexander H. Malick, D.M.D. And staff to perform those procedures that may be necessary or advisable for diagnosis, treatment planning, and completion of dental services for the above named patient.

Patient Signature
(Authorization must be signed by the patient, or by the responsible party in the case of minor, or when the patient is physically or mentally incompetent.)

Relationship to Patient

Date

Doctor's Signature

Date