Bullock Family Dental

Health History

Health History

Name:

Today's Date: ____/____/____ Birthdate: ____/____/____

Physician's Name:

Phone #:

Are you currently under the care of a physician?

Please explain:

Do you now, or have you used?

Tobacco ☐ Alcohol ☐ IV Drugs ☐ Other ☐

Have you ever had a blood transfusion? Y N

Have you ever taken PhenPhen/Fosamax/Boniva? Y N

Please list any prescriptions or over the counter drugs you are taking:

Please list any hospitalizations or major surgeries in the last 5 years:

List any serious medical condition(s) that you have experienced (not listed above):

Have you ever been asked to take antibiotics before a dental appointment?

For Women

Are you taking birth control pills? Y N

Are you pregnant? Y N
If yes, how many weeks?

Are you nursing? Y N

Allergies

Please check if you have allergies to the following.

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Sulfa Drugs
☐ Erythromycin ☐ Other
☐ Latex

For office use only BP: Pulse:

Medical Conditions

Please check if you have experienced any of the following diseases or medical conditions.

☐ Abnormal Bleeding	☐ Fainting Spells/Dizzy	☐ Liver Disease
☐ Alcohol/Drug Abuse	☐ Frequent/ Severe Headache	☐ Mitral Valve Prolapse
☐ Anemia	☐ Glaucoma	☐ Pacemaker
☐ Arthritis	☐ Growths	☐ Psychiatric Treatment
☐ Artificial Joint (Hip/Knee)	☐ Hay Fever	☐ Radiation Treatment
☐ Artificial Heart Valve	☐ Head Injury	☐ Rheumatic Fever
☐ Asthma	☐ Heart Attack	☐ Scarlet Fever
☐ Bruise Easily	☐ Heart Murmur	☐ Sinus Problems
☐ Cancer/Tumor	☐ Heart Surgery	☐ Steroid Therapy
☐ Chemotherapy	☐ Heart Issue/ Other	☐ Stroke
☐ Colitis/Ulcers	☐ Hemophilia	☐ Thyroid Disease
☐ Congenital Heart Defect	☐ Hepatitis ABC	☐ Tuberculosis (TB)
☐ Diabetes	☐ Herpes/Fever Blisters	☐ Ulcer/Stomach Problems
☐ Difficulty Breathing	☐ High/Low Blood Pressure	☐ Venereal Disease
☐ Emphysema	☐ HIV+/AIDS	
☐ Epilepsy/ Seizures	☐ Kidney Disease	

Dentist's Initial *Date*

Dentist's Initial *Date*

Dentist's Initial *Date*