Health History

Name: _____ **Date:** _____

Name of your medical physician_____

Name of pharmacy you use_____

Females are you using oral contraceptives (birth control pills) YES NO

Are you allergic to any medication YES NO
List: _____

Have you ever been hospitalized YES NO
List_____

Are you currently taking any medication YES NO
List: _____
_____

Do you require antibiotic premedication prior to dental treatment for heart valve replacement, joint replacement, previous endocarditis, mitro valve prolapse, heart murmur, or splenectomy YES NO

Circle any of the conditions below that you have or have had in the past

Stroke	Heart problems, attack, or surgery	Epilepsy or seizures
Heart murmur	Pacemaker, hear valve replacement	Kidney disorders
HIV or AIDS	Asthma, emphysema, tuberculosis	Fainting or dizziness
Jaundice	Radiation or chemotherapy	Fibromyalgia
Hepatitis type___	Hypertension (high blood pressure)	Joint replacement
Splenectomy	Diabetes: Type I or Type II	Blood transfusion
Anemia	Hemophilia or blood disorder	Cold sore (herpes)
Bleach allergy	Chest pain/angina	Atrial Fibrillation
Latex allergy	Previous endocarditis	Osteoporosis

Autoimmune disease_____

I understand that the above information is accurate to the best of my knowledge and I have answered each of them truthfully.

Signature: _____