



SIX-MONTH HEALTH HISTORY FORM

MEDICAL / DENTAL HISTORY:

Are you experiencing dental pain or discomfort? YES NO
 Are you in good general health? YES NO
 Do you smoke or use tobacco products? YES NO
 Women: Are you pregnant or suspect you might be? YES NO
 Has there been a change in your general health within the past year? YES NO

Please explain: _____

Are you under the care of a physician? YES NO

If so, what condition is being treated? _____

Physician's Name _____ Phone Number _____

Please check any of the following that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS (AI) | <input type="checkbox"/> Diabetes (DB) | <input type="checkbox"/> Hives (HI) |
| <input type="checkbox"/> Alcoholism (AL) | <input type="checkbox"/> Drug Dependency (DD) | <input type="checkbox"/> Hyper Activity (HY) |
| <input type="checkbox"/> Anemia (AN) | <input type="checkbox"/> Eating Disorder (ED) | <input type="checkbox"/> Hypoglycemia (HG) |
| <input type="checkbox"/> Angina (AG) | <input type="checkbox"/> Emphysema (EM) | <input type="checkbox"/> Jaundice (JC) |
| <input type="checkbox"/> Artificial Heart Valve (AV) | <input type="checkbox"/> Epilepsy (EP) | <input type="checkbox"/> Kidney/Liver Disease (KL) |
| <input type="checkbox"/> Artificial Joints (AJ) | <input type="checkbox"/> Fainting / Dizziness (FD) | <input type="checkbox"/> Mitral Valve Prolapse (HV) |
| <input type="checkbox"/> Arthritis / Rheumatism (AR) | <input type="checkbox"/> Fever Blisters / Cold Sores (FS) | <input type="checkbox"/> Night Sweats (NS) |
| <input type="checkbox"/> Asthma (A) | <input type="checkbox"/> Gag Easily (GE) | <input type="checkbox"/> Osteoporosis (OS) |
| <input type="checkbox"/> Birth Control (BC) | <input type="checkbox"/> Glaucoma (GL) | <input type="checkbox"/> Paralysis (PL) |
| <input type="checkbox"/> Blood Pressure - High (BH) | <input type="checkbox"/> Headaches - Frequent (HF) | <input type="checkbox"/> Prolonged Bleeding (PB) |
| <input type="checkbox"/> Blood Pressure - Low (BL) | <input type="checkbox"/> Heart Attack (HA) | <input type="checkbox"/> Psychiatric Treatment (PT) |
| <input type="checkbox"/> Blood Thinners (BT) | <input type="checkbox"/> Heart Murmur (HM) | <input type="checkbox"/> Rheumatic Fever (RF) |
| <input type="checkbox"/> Bruise Easily (BB) | <input type="checkbox"/> Hemophilia (HP) | <input type="checkbox"/> Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Cancer (CA) | <input type="checkbox"/> Hepatitis (H) | <input type="checkbox"/> Sickle Cell Disease (SD) |
| <input type="checkbox"/> Chemotherapy / Radiation (CR) | <input type="checkbox"/> Hereditary Dis. / Deformities (HD) | <input type="checkbox"/> Sinus Trouble (ST) |
| <input type="checkbox"/> Congenital Heart Disease (CH) | <input type="checkbox"/> HIV Positive (VP) | <input type="checkbox"/> Stroke (SK) |
| <input type="checkbox"/> Deaf (DF) | <input type="checkbox"/> Herpes (HR) | <input type="checkbox"/> Tuberculosis (TB) |
| | | <input type="checkbox"/> Tumors (TM) |

Have you had any other serious illness(es) in the past six months? Yes No

If yes to any of the above, please explain: _____

DRUGS / MEDICATIONS:

Are you allergic to or have you had a bad reaction to:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Aspirin (AA) | <input type="checkbox"/> Iodine (AD) | <input type="checkbox"/> Narcotics (NA) | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates (AB) | <input type="checkbox"/> Keflex (AK) | <input type="checkbox"/> Penicillin (AP) | <input type="checkbox"/> Other Allergies: _____ |
| <input type="checkbox"/> Codeine (AC) | <input type="checkbox"/> Local Anesthetic (LA) | <input type="checkbox"/> Sulfa (AS) | _____ |
| <input type="checkbox"/> Erythromycin (AE) | <input type="checkbox"/> Nitrous Oxide (NO) | <input type="checkbox"/> Tetracycline (AT) | _____ |

Have you taken any medication in the last six months? Yes No

Please list: _____

Please list any medication(s) you are taking now: _____

Reason(s): _____