Hatch & Jeppson Dental
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HEALTH HISTORY

Patient Name_____ **Date of Birth**_____
Physician's Name_____ **Physician's Phone #**_____
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Have you ever had any of the following?

__ *Angina*
__ *Anti-coagulant medication*
__ *Atrial fibrillation*
__ *Bruise easily or prolonged bleeding*
__ *Cancer or chemotherapy*
__ *Cold sores*
__ *Congestive heart failure*
__ *Fainting or dizzy spells*
__ *Heart attack (MI)*
__ *Hemophilia or VonWillebrands*
__ *Hepatitis*
__ *High blood pressure*
__ *HIV*
__ *Irregular heart beat*
__ *Kidney trouble*
__ *Liver disease*
__ *Psychiatric treatment*
__ *Radiation treatment*
__ *Shortness of breath*
__ *Sickle cell disease*
__ *Stroke or TIA's*
__ *Thyroid Disease*
__ *Tuberculosis*
__ *Unexplained weight loss*

Premed Questions

Have you ever had any of the following?

__ *Any artificial shunt or catheter*
__ *Artificial heart valve*
__ *Chemotherapy*
__ *Congenital heart defect*
__ *Diabetes (Type I or II)*
__ *Endocarditis*
__ *Hemodialysis*
__ *Organ transplant*
__ *Prosthetic joint*
__ *Spleen removal*

Sedation Questions

Have you ever had any of the following?

__ *Frequent alcohol or disulfaram use?*
__ *Asthma?*
__ *Chromic obstructive pulmonary disease (COPD)?*
__ *Diabetes or Hypoglycemia?*
__ *Glaucoma?*
__ *History of heart attack?*
__ *Recreational drug use?*
__ *Seizures?*
__ *Sleep apnea?*
__ *Vitamin B12 Deficiency?*

1. Have you taken biphosphonate medication like Fosomax, Aredia, Zometa, or Actonel? YES NO
2. Are you presently taking any medications or drugs on a regular basis? If so, please list YES NO
(including oral contraceptives)_____
_____
3. Are you allergic to any medicines or materials? (Penicillin, Latex, Codeine, Ibuprofen, etc) YES NO
_____
4. Do you have any diseases not listed above? _____
5. Have you ever had a severe reaction to any dental or local anesthetics? YES NO
6. Are you pregnant or nursing? If yes, due date_____ YES NO

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Signature of Patient, Parent, or Guardian_____ **Date**_____