

**Patient's Name** \_\_\_\_\_ **Birth date** \_\_\_\_\_

**Health Information**

Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Are you currently being treated or have been treated in the last year by a physician or hospitalized? YES NO  
 If YES, please explain: \_\_\_\_\_

**List of ALL Drugs, Medications, Over-the-counter Medication, Natural Herbal Remedies:**

**Allergies or Sensitivity: (circle all that apply)**

Metals	Dental Anesthetic	Latex
Codeine, or other narcotics	Penicillin or other antibiotic	Other: _____
Aspirin	Barbituates, Sedatives	_____

**Do you have or have you had: (circle all that apply)**

Heart Disease	Diabetes	Chemotherapy	Stomach Problems
Heart Attack	High Cholesterol	Artificial Joints	Ulcers
Stroke	Blood Disorders	Arthritis	Epilepsy
Heart Defect	Bleeding Problems	Rheumatism	Seizures
Mitral Valve Prolapse	Bruise Easily	Osteoporosis	Fainting Spells
Heart Murmur	Liver Disease	Asthma	Mental Illness
Pacemaker	Hepatitis	Lung Disease	Bipolar
Artificial Heart Valve	Kidney Disease	Sinus Trouble	Depression
Rheumatic Fever	Tumors or Cysts	Eye Disease	Venereal Disease
Stroke	Cancer	Glaucoma	AIDS
High Blood Pressure	Radiation Treatment	Ear Trouble	HIV positive

**Are you taking or have taken:**

Tobacco in any form Yes No Frequency \_\_\_\_\_  
 Alcohol Yes No Frequency \_\_\_\_\_  
 Fen-Phen or Redux Yes No  
 Bisphosphonates (ie Fosamax) Yes No

**For Women Only:**

Are you or could you be pregnant? Yes No  
 Delivery Date \_\_\_\_\_  
 Are you nursing? Yes No  
 Are you taking birth control pills? Yes No

**All Patients:**

Do you require **antibiotic prophylaxis** prior to any dental treatment? Yes No  
 Do you have or have you had any **other diseases or medical problems NOT listed** on this form? Yes No  
 If YES, please explain: \_\_\_\_\_

**Consent for Treatment:**

I, the undersigned, have read, understand, and have truthfully answered the above health history. I agree to voluntarily advise Dr. Inong and staff of any change of medical conditions in the future before beginning any dental care. I agree to the release of medical records as needed for dental care. I authorize Dr. Inong and staff to take x-rays, study models, or any other diagnostic aids deemed appropriate by Dr. Inong to make a thorough dental diagnosis. I also authorize Dr. Inong and staff to perform any and all forms of treatment, medication, and therapy that may be indicated with (patient's name) \_\_\_\_\_'s case. I also understand the use of anesthetic agents embodies a certain risk.

<b>Signature</b> _____	<b>Relation to Patient</b> _____	<b>Date</b> _____
------------------------	----------------------------------	-------------------

**Health History Review**

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Reviewed by** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Reviewed by** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Reviewed by** \_\_\_\_\_