

Mock Family Dentistry Confidential Health History

Patient Name

Birthdate

Are you allergic to or have you ever had reactions to:

| | | |
|-----------------------------------------------|-----|----|
| Local anesthetics like Novocain..... | Yes | No |
| Penicillin or other antibiotics..... | Yes | No |
| Sulfa drugs..... | Yes | No |
| Codeine or other medications..... | Yes | No |
| Aspirin..... | Yes | No |
| Household bleach..... | Yes | No |
| Any metals (e.g., nickel, mercury, etc.)..... | Yes | No |
| Latex or rubber..... | Yes | No |
| Other (please specify)..... | Yes | No |

Do you have or have you ever had the following:

| | | |
|----------------------------------------|-----|----|
| Diabetes..... | Yes | No |
| Liver disease..... | Yes | No |
| Kidney disease..... | Yes | No |
| Bleeding disorder..... | Yes | No |
| High Blood Pressure..... | Yes | No |
| Heart attack, angina or pacemaker..... | Yes | No |
| Rheumatic fever..... | Yes | No |
| Stroke | Yes | No |
| Heart murmur..... | Yes | No |
| Mitral valve prolapsed | Yes | No |
| Artificial joint replacement..... | Yes | No |

Has your physician advised you to medicate with antibiotics due to a heart condition, artificial joints or transplants? If 'yes', please list medications:

| | | |
|------------------------------------|-----|----|
| Hay fever..... | Yes | No |
| Asthma | Yes | No |
| Hepatitis (A,B or C) | Yes | No |
| Sexually Transmitted Disease | Yes | No |
| Positive HIV test | Yes | No |
| Active TB | Yes | No |
| Snoring &/or sleep apnea | Yes | No |
| Ulcers | Yes | No |
| Gum problems..... | Yes | No |

Do you smoke? Y N Have you ever smoked? Y N

Are you pregnant? Y N If so, what is your due date?

Please list any medical condition not listed above:

Physician name

Phone

Patient Signature

Date