NORTHSIDE
DENTAL CLINIC

Health History

All information is confidential

Patient's Name: ____ Date of Birth: ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Question	Y	N	
Are you under a Physician's care now? If yes, list physician's name and phone #	Y	N	
Have you ever been hospitalized or had a major operation?	Y	N	Explanation:
Have you ever had a serious head or neck injury?	Y	N	
Are you taking any medications including non-prescription drugs, vitamins and herbs?	Y	N	List:
Are you required to take an antibiotic (pre-medication) before having dental treatment?	Y	N	Reason:
Do you take, or have you taken Phen-Fen or Redux?	Y	N	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y	N	
Do you use tobacco/nicotine products?	Y	N	Type:

Any drug or food allergies? **YES NO** If so, please list them here:______________________________________

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Are you allergic to latex? (Please circle) **YES NO**

Women:	**Y**	**N**		**Y**	**N**
Are you pregnant?			Are you nursing?		
-Estimated Due Date:			Are you taking any birth control prescriptions?		

CONTINUED ON NEXT PAGE- PLEASE TURN OVER

Do you have, or have you had any of the following?

ADD/ADHD	**Y**	**N**	**Aids/HIV**	**Y**	**N**	**Alcoholism**	**Y**	**N**	**Allergies/Hives**	**Y**	**N**
Anemia	**Y**	**N**	**Arthritis/Gout**	**Y**	**N**	**Artificial Heart Valve**	**Y**	**N**	**Asperger Syndrome/Autism**	**Y**	**N**
Aspirin Therapy/ Blood Thinner	**Y**	**N**	**Asthma/Breathing problems**	**Y**	**N**	**Blood Transfusion**	**Y**	**N**	**Chest Pains**	**Y**	**N**
Cold Sores/ Fever Blisters	**Y**	**N**	**Dementia/ Alzheimer's**	**Y**	**N**	**Diabetes**	**Y**	**N**	**Dizziness/Fainting**	**Y**	**N**
Epilepsy/ Seizures	**Y**	**N**	**Excessive Bleeding**	**Y**	**N**	**Frequent Headaches**	**Y**	**N**	**Gastrointestinal Issues**	**Y**	**N**
Hearing Difficulty/ Impaired	**Y**	**N**	**Heart Disease**	**Y**	**N**	**Heart Murmur**	**Y**	**N**	**Heart Attack/Failure**	**Y**	**N**
Hepatitis A	**Y**	**N**	**Hepatitis B or C**	**Y**	**N**	**High Blood Pressure**	**Y**	**N**	**Low Blood Pressure**	**Y**	**N**
Joint Replacement	**Y**	**N**	**Kidney Disease/ Dialysis**	**Y**	**N**	**Liver Disease**	**Y**	**N**	**Lung Disease**	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	**Mouth Sores/ Growths**	**Y**	**N**	**Osteoporosis (Bone Disease)**	**Y**	**N**	**Pace Maker/Heart Surgery**	**Y**	**N**
Pain in Jaw	**Y**	**N**	**Psychiatric Treatment**	**Y**	**N**	**Recreational Drug Use**	**Y**	**N**	**Rheumatic Fever**	**Y**	**N**
Ringing in ears	**Y**	**N**	**Sinus Problems**	**Y**	**N**	**Stroke**	**Y**	**N**	**Thyroid Disease**	**Y**	**N**
Tuberculosis (TB)	**Y**	**N**	**Venereal Disease**	**Y**	**N**						

Do you have, or have you had any type of Cancer **YES NO** If yes, what type?____________________________

If you have had Cancer, did you receive any of the following treatments?

Chemotherapy **YES NO** Radiation Treatment **YES NO**

Have you ever had any serious illness or disease not listed above? **YES NO**

If yes____

I have read and completed all items in good faith and as accurately as possible.

Patient/Guardian Signature ____ **Date** __________