DENTAL HEALTH CENTER
22216 Loop 494
New Caney, TX 77357
Phone: (281) 354 – 2244

So we may provide you with the best possible care, it is important that you answer the following information as completely as possible. This information is confidential between you and our dental office. Thank You.

Health History

Please circle "Y" for Yes or "N" for No to indicate if you have had any of the following:

ADHD	Y / N	Fibromyalgia	Y / N	Polio	Y / N
AIDS	Y / N	Glaucoma	Y / N	Psychiatric Care	Y / N
Anemia	Y / N	Hashimoto	Y / N	Radiation Treatment,When?_____	Y / N
Anxiety	Y / N	Headaches	Y / N	Where?_____	
Arthritis	Y / N	Heart Attack, When?_____	Y / N	Respiratory Disease	Y / N
Artificial Heart Valves	Y / N	Heart Disease	Y / N	Respiratory Problems	Y / N
Artificial Joints,When_____	Y / N	Heart Murmur	Y / N	Rheumatic Fever	Y / N
Where?_____		Heart Palpitations	Y / N	Rheumatism	Y / N
Asthma	Y / N	Heart Problems	Y / N	Scarlet Fever	Y / N
Autism	Y / N	Heart Valve Replacement,	Y / N	Scoliosis	Y / N
Back Problems	Y / N	When?_____		Shortness of Breath	Y / N
Bleeding abnormally	Y / N	Hemophilia	Y / N	Sinus Trouble	Y / N
Blood Disease	Y / N	Henoch Schonlein Purpura	Y / N	Skin Rash	Y / N
Breathing Problems	Y / N	Hepatitis Type _____	Y / N	Special Diet	Y / N
Cancer, When?_____	Y / N	Herpes	Y / N	Stent, When?_____	Y / N
Where?_____		High Blood Pressure	Y / N	Stroke, When?_____	Y / N
Chemical Dependency	Y / N	Hyperthyroidism	Y / N	Swollen feet or ankles	Y / N
Chemotherapy	Y / N	HIV	Y / N	Swollen neck glands	Y / N
Circulatory Problems	Y / N	Irregular Heartbeat	Y / N	Synthetic Aorta, When?_____	Y / N
Congenital Heart Defect	Y / N	Jaundice	Y / N	Tachycardia	Y / N
Congenital Heart Failure	Y / N	Jaw Pain	Y / N	Thyroid Disease/Problems	Y / N
Congenital Heart Lesions	Y / N	Kidney Disease	Y / N	Tonsillitis	Y / N
Cortisone Treatments	Y / N	Lens Implant	Y / N	Transient Ischemic Attack (TIA)	Y / N
C.O.P.D	Y / N	Liver Disease	Y / N	Tuberculosis	Y / N
Cough, Persistent or Bloody	Y / N	Low Blood Pressure	Y / N	Tumor or growth on head or neck	Y / N
Diabetes	Y / N	Lung Transplant, When?_____	Y / N	Ulcer	Y / N
Defibrillator	Y / N	Mitral Valve Prolapse,When?_____	Y / N	Unexplained Weight Loss	Y / N
Dementia	Y / N	Multiple Sclerosis	Y / N	Venereal Disease	Y / N
Dialysis	Y / N	Myasthenia Gravis	Y / N	Wear contact lenses	Y / N
Down Syndrome	Y / N	Nervous Problems	Y / N		
Eczema	Y / N	Open Heart Surgery,	Y / N	Other not listed:	
Emphysema	Y / N	When?_____		_____	
Epilepsy	Y / N	Pacemaker	Y / N	_____	
Essential Tremors	Y / N	Pins or Plates,When?_____	Y / N	_____	
Fainting or Dizziness	Y / N	Where?_____			

FEMALES ONLY

Are you pregnant? Y/N If yes, due date? _____ Are you nursing? Y/N Are you taking birth control? Y/N

MEDICATIONS:

Please list all the medication(s) you are currently taking:_____

_____

_____

ALLERGIES:

Please circle if you're allergic to any of the following: Codeine, Latex, Penicillin, Amoxicillin, Cipro, Clindamycin, Fluoride, Tylenol #3, Augmentin, Local Anesthetic, Erythromycin, Sulfa, Iodine, Ibuprofen/Motrin/Advil, Acetaminophen/Tylenol

If not listed above, please write any other allergies to medications or food:

_____

_____

Patient Name:_____ Date:_____

Signature:_____ Relationship to patient:_____