Name: _____ Date: _____

Health History

Name of Physician:_____Phone:_____Date of Last Exam:_____

Are you under medical treatment now? _____ If yes, for what? _____

Have you been hospitalized for illness or surgery within the last 5 years? _____ If yes, what for? _____

Do you use tobacco/vape products? _____ Do you use recreational drugs? _____

Are you taking any medication? _____ If yes, what are you taking? (can email list to fdsahakian@gmail.com)

_____

Are you *allergic* to any of the following? (check if yes)

_____ *Penicillin* _____ *Amoxicillin* _____ *Erythromycin* _____*Clindamycin*
_____ *Aspirin* _____ *Sulfa Drugs* _____ *Latex Rubber* _____*Tree Nuts/ Nuts*
_____ *Any Metals (nickel, mercury, etc.)* _____*Other:* _____

Do you have any of the following? (Check if yes): ***** may require pre-medication***

_____*Joint Replacement** _____*Respiratory Problem* _____*Epilepsy/ Convulsions*
_____*Rheumatic Fever** _____*Tuberculosis* _____*Stroke*
_____*Heart Disease* _____*High Blood Pressure* _____*Thyroid Problems*
_____*Heart Murmur** _____*Low Blood Pressure* _____*Arthritis*
_____*Heart Attack* _____*Anemia* _____*Cancer:* _____
_____*Mitral Valve Prolapse** _____*AIDS/ HIV* _____*Radiation Therapy*
_____*Valve Replacement** _____*Kidney Disease* _____*Chemo Therapy*
_____*Pacemaker/Stent* _____*Liver Disease* _____*Recovering Addict*
_____*Chest Pains* _____*Jaundice/ Hepatitis* _____*Dental Anxiety*
_____*Angina* _____*Diabetes* _____*Other:* _____

Women Only (check if yes):
_____Are you pregnant or think you may be pregnant?
_____Are you nursing?
_____Are you taking contraceptives?

New or Existing Patients

Do you see a specialty dentist? (i.e. Orthodontist, Periodontist, Endodontist, Oral Surgeon for x-rays)

Y ___ N ___ If yes, who? _____

Name of Previous Dentist: _____ **Date of Last Exam**: _____

Signature: _____ Phone: _____

Scanned _____