CONFIDENTIAL
HEALTH HISTORY

Name: _____

Name you prefer to be called: _____ Birthdate _____

Medical History

Who is your medical doctor? _____ MD's phone #: _____

How would you rate your current health? _____ Good _____ Fair _____ Poor

Are you under a doctor's care now? Yes / No Please explain: _____

Have you been hospitalized in the last 2 years? Yes / No Please explain: _____

List any prescribed medications and reason for use: _____

Are you allergic to any medications or products? Yes / No

Specify: _____

Please check if you have had any of the following:

_____ Cholesterol	_____ Sinus trouble	_____ Chemotherapy/radiation	_____ Hepatitis
_____ Heart trouble	_____ Allergies / Hay fever	_____ Immunodeficiency disease	_____ Asthma
_____ Heart murmur	_____ Arthritis	_____ Eating disorder	_____ Stroke
_____ Rheumatic fever	_____ Alzheimer's	_____ Artificial joint	_____ Diabetes
_____ Pacemaker	_____ Epilepsy/seizures	_____ Fainting/dizziness	_____ Cancer
_____ Mitral valve prolapse	_____ High blood pressure	_____ Drug/alcohol addiction/rehab	_____ Glaucoma
_____ Artificial heart valve	_____ Ulcers/stomach problem	_____ Emphysema	

Have you had any other serious illness not checked above? Describe: _____

For Women: Are you pregnant? Yes / No / Unsure Due date _____ Nursing? Yes / No

Dental History

What? _____

Has your physician advised you to take an antibiotic before dental treatment? ____ Yes ____ No Dosage _____

Have you ever been diagnosed with gum disease? ____ Yes ____ No

Have you ever had a reaction to dental anesthetic? ____ Yes ____ No Describe: _____

Do you smoke or use tobacco in any form? ____ Yes ____ No Describe: _____

Have you ever had orthodontic treatment? ____ Yes ____ No

Do you clench or grind your teeth? ____ Yes ____ No

Do you feel nervous about dental treatment? ___ Yes ___ No Explain: _____

Do you get cold sores, fever blisters or canker sores? ____ Yes ____ No

Do you have clicking, popping, or discomfort in the jaw joints? Describe: _____

For children: Does the child take a fluoride supplement? ____ Yes ____ No

Treatment Authorization

I understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize Dr. Worthington to perform diagnostic and therapeutic procedures as may be necessary for proper dental care.

_____ _____

Patient Signature (Parent/Guardian) Date

For Office Use only:

Reviewed by / date		Reviewed by / date
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____