# Health History

Patient's Name: _____

Physician's name: _____ Approximate date of last physical exam: _____

Have you been hospitalized recently, if so why? _____

Have you experienced prolonged or abnormal bleeding with previous dental extractions, surgery or trauma?

_____

Have you had a serious illness, operation, or undergone radiation therapy to treat a tumor or other conditions? (Please specify)

_____

Do you snore? ☐ Yes ☐ No

**Please indicate your average daily consumption of the following, if applicable**:

Soda _____ Coffee _____ Tea _____ Tobacco _____ Recreational Drugs _____ Alcohol _____

**Place a mark on all that apply to indicate if you have or had any of the following**: ☐No to all

☐ AID/HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints (When: _____)
☐ Asthma
☐ Bleeding Abnormally
☐ Cancer (Type: _____)
☐ Chemotherapy
☐ Diabetes
☐ Drug Dependency
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy
☐ Fainting or Dizziness
☐ Glaucoma
☐ Headaches / Migraines
☐ Heart Problems
☐ Hepatitis (Type: _____)
☐ High Cholesterol
☐ High / Low Blood Pressure
☐ Hives / Skin Rash
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Organ Transplant
☐ Osteoporosis
☐ Pacemaker
☐ Prosthetic Heart Valve
☐ Psychiatric Care
☐ Respiratory disease
☐ Rheumatic Heart Disease
☐ Sinus Trouble
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease
☐ **Premedication Required**

**Reason: _____**

**Women:**

☐ Pregnant
☐ Taking birth control
☐ Nursing

Other health conditions not mentioned: _____

**Medications (Attach list if necessary)**: ☐None

| **Medication / Dosage** | **Reason for Medication** | **Medication / Dosage** | **Reason for Medication** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Allergies:** ☐Penicillin ☐Aspirin ☐Codeine ☐Latex ☐Local Anesthetic ☐Other:_____ ☐None

This information is accurate to the best of my knowledge. I authorize the use of this information for treatment consultation with other health care practitioner.

Dental photographs are essential for dentist/client communication. I also hereby consent to and approve use by **Evergreen Dental** of dental and facial photographs of me, for scientific or marketing purposes.

☐ I prefer that only my dental photographs and not those of my face, be used for scientific or marketing purposes.

I authorize release, to my insuring company plans administrator and CDANet, information contained in claims submitted electronically and for the communication of information related to the coverage of services rendered by **Evergreen Dental.** This authorization shall continue in effect until the undersigned revokes the same.

_____ _____

Patient signature (or responsible party if under 18 years of age) Date