Health History

Patient name : _____ (First name) _____ (Mid name) _____ (Last name)

Skin Cancer : ☐ Yes ☐ No Type : ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Malignant melanoma

Other types of skin cancer : ☐ Yes ☐ No Type : _____

History heart problems : ☐ Yes ☐ No ☐ Artificial heart valve ☐ Heart murmur ☐ Pacemaker ☐ Defibrillator

Bleeding disorders : ☐ Yes ☐ No Type : _____

History of blood transfusions : ☐ Yes ☐ No

High blood pressure : ☐ Yes ☐ No

Arthritis : ☐ Yes ☐ No

Artificial joints : ☐ Yes ☐ No Type : _____

Neurological disease : ☐ Yes ☐ No Type : _____

Headaches : ☐ Yes ☐ No Type : _____

Psychiatric history : Depression : ☐ Yes ☐ No Other : _____

Auto-immune disease : ☐ Yes ☐ No Type : ☐ Lupus ☐ Rheumatoid arthritis _____

Eye disease : ☐ Yes ☐ No Type : ☐ Glaucoma ☐ Cataracts _____

Seasonal allergies : ☐ Yes ☐ No

Endocrine disease : ☐ Yes ☐ No Type : ☐ Diabetes ☐ Thyroid problem _____

Have you ever had X-ray treatment for acne ? ☐ Yes ☐ No

HIV/AIDS : ☐ Yes ☐ No

Liver disease : ☐ Yes ☐ No Type : Hepatitis B : ☐ Yes ☐ No / Hepatitis C : ☐ Yes ☐ No _____

Family history of skin cancer : ☐ Yes ☐ No Type : _____

Family history of medical problems : ☐ Yes ☐ No Type : _____

Social history : ☐ Yes ☐ No Smoke : ☐ Yes ☐ No, packs per day _____
Alcohol : ☐ Yes ☐ No, drinks per week _____

Sexually transmittied disease : ☐ Yes ☐ No Type : _____

Illicit drugs : ☐ Yes ☐ No Type : _____

Other medical problems : ☐ Yes ☐ No Type : _____

Surgical history : List : _____

History of accidents in last 5 years : List : _____

Hospitalizations in last 5 years : List : _____

Medication allergies : ☐ Yes ☐ No List : _____

List medications currently taking : _____

Have you previously taken antibiotics prior to dental cleanings/procedures : ☐ Yes ☐ No

WOMEN ONLY : OB/GYN : Breast Feeding : ☐ Yes ☐ No Pregnant : ☐ Yes ☐ No Planning Pregnancy : ☐ Yes ☐ No

Signature : _____ Date : _____