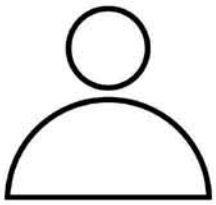
Patient Health History Date:

Allergies

- [ ] Allergic to Acrylic
- [ ] Allergic to Aspirin
- [ ] Allergic to Codeine
- [ ] Allergic to Latex
- [ ] Allergic to Local Anesthetics
- [ ] Allergic to Metal
- [ ] Allergic to Penicillin
- [ ] Allergic to Sulfa Drugs
- [ ] Anaphylaxis
- [ ] Other Allergy
- [ ] Sinus Trouble

Medications

- [ ] Cortisone Medicine
- [ ] Pre-Med Required



First Name:

Last Name:

Birth Date:

Musculoskeletal

- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Artificial Joint
- [ ] Bruise Easily
- [ ] Cold Sores/Fever
- [ ] Blisters
- [ ] Rheumatism
- [ ] Swelling of Limbs
- [ ] Tumors or Growths

Organs

- [ ] Asthma
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Parathyroid Disease
- [ ] Renal Dialysis
- [ ] Stomach/Intestinal Disease
- [ ] Thyroid Disease
- [ ] Ulcers
- [ ] Yellow Jaundice

Cardiovascular

- [ ] Anemia
- [ ] Angina
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Hypoglycemia
- [ ] AIDS/HIV Positive
- [ ] Artificial Heart Valve
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problem
- [ ] Chest Pains
- [ ] Congenital Heart Disorder
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Excessive Bleeding
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Heart Trouble/ Disease
- [ ] Hemophilia
- [ ] High Cholesterol
- [ ] Irregular Heartbeat
- [ ] Leukemia
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mitral Valve Prolapse
- [ ] Sickle Cell Disease

Nervous

- [ ] Alzheimer's Disease
- [ ] Seizures
- [ ] Stroke
- [ ] Fainting Spells/ Dizziness
- [ ] Frequent Headaches
- [ ] Psychiatric Care
- [ ] Spina Bifida

Dental

Miscellaneous

- [ ] Cancer
- [ ] Glaucoma
- [ ] Tuberculosis
- [ ] Chemotherapy
- [ ] Convulsions
- [ ] Drug Addiction
- [ ] Hay Fever
- [ ] Pregnant/Trying to get pregnant
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Rheumatic Fever
- [ ] Tonsillitis

Are you currently under the care of a physician?	Are you on a special diet?	Have you had any serious neck or head injuries?
Do you experience any pain in your teeth?	Do you suffer from TMJ?	Do you use controlled substances?
Do you use tobacco, if so how frequently?	Taking any oral contraceptives?	Do you have any other health issues or concerns that were not listed?

I certify that the information I have provided is true.