Health History Form

Name_____ Age_____ Height_____ Weight_____

Are you taking any medications? Yes or No
If yes, please list medications _____
Do you have any allergies? Yes or No
If yes, please specify _____

Have you ever had surgery? Yes or No
If yes, please specify _____

Please mark an (X) in the appropriate column indicating whether you have or have not had the following medical conditions

	YES	NO
Cardiovascular disease		
Artificial (prosthetic) heart valve		
Previous infective endocarditis		
Damaged heart valves		
Heart attack		
Heart murmur		
Pacemaker		
Rheumatic fever		
High blood pressure		
Stroke		
Bleeding disorders		
Hemophelia		
Sickle cell disease or trait		
Rheumatoid arthritis		
Lupus		
Sarcoidosis		
Respiratory Disease		
Asthma		
Bronchitis		

Emphysema		
History of chemotherapy/radiation treatment		
Diabetes Type I/Type II		
Neurological Disorders		
Chronic Pain		
Joint Replacement		
TMJ Disorder		
Acid reflux/GERD		
Liver Disease		
Kidney Disease		
Sleeping Disorders		
Chronic fatigue		
Obstructive Sleep Apnea		

Are you pregnant? Yes or No
Date of last menstrual period? _____

Do you or your family members have problems/complications with anesthesia? Yes or No

I have answered the following questions to the best of my ability. I understand that my answers will be used to determine the most appropriate treatment. I will not hold the dentist, anesthesiologist, or staff responsible for any omissions or errors I have made in the completion of this form.

Signature of Patient/Legal Guardian _____Date_____

Signature of Anesthesiologist _____Date_____