Today's Date:

Warner Family Dentistry, LLC

Health History Form

Name:_____

DOB:_____ Phone #:_____ Height:_____ Weight:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

***If you have any of the following problems, please notify the receptionist before completing this form:**

-Active Tuberculosis -Persistent cough greater than a 3 week duration

-Cough that produces blood -Been exposed to anyone with tuberculosis

Date of last dental exam:_____

Date of last dental x-rays:_____

Please circle YES or NO & explain if necessary:

Are you under the care of a physician?.....YES NO

Physician's name:_____ Phone #:_____

Has there been any change in your general health within the past year?.....YES NO

If yes, please explain:_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years?.....YES NO

If yes, please explain:_____

***Please list all MEDICATIONS you are taking:**

_____

_____

_____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....YES NO

Are you or have you taken any of the following drugs? Fosamax, Actonel, Aredia, or Zometa……YES NO

Do you have: artificial heart valve, previous infective endocarditis, or congenital heart disease?.....YES NO

***Please list all ALLERGIES:**_____

Do you use controlled substances (drugs)?.....YES NO

Do you use tobacco?.....YES NO

Do you drink alcoholic beverages?.....YES NO

If yes, how much do you typically drink in a week?_____

(Over)

WOMEN ONLY Are you:

Pregnant?.....YES NO

Taking birth control or nursing?.....YES NO

Please circle to indicate if you currently have or previously had any of the following problems:

Cardiovascular disease	Asthma
Angina	Bronchitis
Arteriosclerosis	Emphysema
Congestive heart failure	Cancer/chemotherapy/radiation treatment
Damaged heart valves	Diabetes Type I or II
Heart attack	Eating disorder
Heart murmur	Gastroesophageal reflux/heartburn
High blood pressure	Ulcers
Mitral valve prolapse	Thyroid problems
Pacemaker	Stroke
Rheumatic fever	Hepatitis, jaundice, or liver disease
Anemia	Fainting or seizures
Blood transfusion	Sleep disorder
Hemophilia	Kidney problems
AIDS or HIV infection	Osteoporosis
Arthritis	Sexually transmitted disease
Migraines	Lupus
Neurological disorders	Mental health disorders

If you have any disease, condition, or problem not listed above that you think we should know about, please explain here:_____

*****I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist will rely on this information for treating me. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

Signature of Patient/Legal Guardian:_____ Date:_____

FOR COMPLETION BY DENTIST

Comments:_____

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