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HEALTH INFORMATION

NAME____

Date of Last Dental Visit:__________________ Reason for today's visit:______________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Exposure to HIV
- ☐ Allergies
  - ☐ Jewelry
  - ☐ Latex
  - ☐ Penicillin
  - ☐ Sulfa
  - ☐ Codeine
  - ☐ Other
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Fibromyalgia
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant
  Due Date______
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Parkinson's
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Blood Thinner
- ☐ Daily Aspirin
- ☐ MVP
- ☐ COPD
- ☐ Other
  - ☐ ____________
  - ☐ ____________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____

Have you been under a physician's care within the past six months? ☐ Yes ☐ No

If yes, please explain: ____

Please list all medications and supplements you are taking at this time (including birth control pills) ________________

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Name of Physician__________________________ Phone__________________________

Do you require pre-medication for your dental visits? ☐ Yes ☐ No

Have you been diagnosed with any heart conditions, i.e., Mitral Valve Prolapse, Heart Murmur, Angina, Etc.?

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Have you been diagnosed with Acute Narrow Angle Glaucoma? ______________________________

Do you have Artificial Joint Replacements? ☐ Yes ☐ No If yes, date of placement______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that this information will be used by Dr. Wilbanks to help determine appropriate and healthful dental treatment. If there is any change in my health or medications, I will inform the doctor at the next appointment without fail.

______________________________________ Date__________________________
SIGNATURE OF PATIENT PARENT OR GUARDIAN