HEALTH HISTORY FORM

Clemson Family Dentistry

Today's Date: _____
Patient Name:

_____

If you are completing this form for another person, what is your relationship to that person?
Your Name: _____
Relationship: _____

Date of Birth: _____ / _____ / _____

Are you now under the care of a physician? _____
Physician Name: _____

Has there been any change in your general health within the past year? _____
If yes, what condition is being treated?

_____

Women Only: Are you pregnant? _____

Please answer the following YES (Y) or NO (N) questions:

	Y	N
Have you had a joint or valve replacement?		
Do you require premedication before dental treatment?		
Do you take bisphosphonates (oral or IV)?		
Do you take any blood thinners?		
Do you take aspirin?		
Do you bruise easily?		

Are you allergic to any of the following:

	Y	N		Y	N
Local Anesthetics			Codeine / narcotics		
Penicillin			Latex		
Other Antibiotics			Other Drug Allergies		
Barbituates, sedative, sleeping pills					
Aspirin					
Sulfa Drugs					

Have you had or experienced any of the following?

	Y	N		Y	N		Y	N		Y	N		Y	N
Any Serious Illness			Hepatitis			Tuberculosis			Rheumatic Fever			Chest Pains		
Operations			Jaundice			Cancer or Tumors			Frequent Severe Headaches			Swelling Ankles		
High Blood Pressure			Anemia			Venereal Disease			Difficulty Breathing			Stroke		
Low Blood Pressure			Stomach Ulcers			Arthritis			Shortness of Breath			Heart Attack		
Diabetes			Glaucoma			Blood Transfusions			AIDS/HIV			Heart Murmur		
Easily Fatigued			Fainting			Skin Rashes			Epilepsy			Drug Addiction		

MEDICATIONS

Are you taking or have you recently taken any prescription medications? If so, please list including dosages if applicable:

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 and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completing of this form.

Signature of Patient/Legal Guardian: _____

Date: _____