Print Form

Towne Pointe Dental

Health History

CHECK IF YOU CURRENTLY HAVE OR EVER HAD ANY OF THE FOLLOWING:

- ☐ AIDS/HIV
- ☐ Allergies: Please list:
- ☐ Anemia: what type:
- ☐ Arthritis
- ☐ Artificial Joint: Year
- ☐ Asthma
- ☐ Blood Disease
- ☐ Chest pain
- ☐ Chronic Cough, > 3 weeks
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fatigue
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head injuries
- ☐ Heart Disease
- ☐ Hepatitis. Type:
- ☐ Heart Murmur/M.V.P.
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of Appetite
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Respiratory Problems
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Unexplained Weight Loss
- ☐ Venereal Disease
- ☐ Other

Please list medications you are taking:

Yes	No	
☐	☐	Smoking: ☐ Present ☐ Past: when did you stop?_____
☐	☐	Recreational drug use: ☐ Present ☐ Past
☐	☐	Are you under the care of a physician? Doctor's Name: Phone:
☐	☐	Do you need to take Pre-Medication such as antibiotics?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient/parents/guardian:

Date: