Time 9:36 AM | Hal E. Hale DDS, PA | Date 1/21/2016

Patient Health History

Patient Name: | Birth Date: | Date Created:

Medical Information

Do you have, or have you ever had any of the following?

AIDS/HIV	Yes No	Chemotherapy	Yes No	Frequest Headaches	Yes No	Hepatitis C	Yes No
Osteoporosis	Yes No	Anemia	Yes No	Cold Sores/Fever Blister	Yes No	Glaucoma	Yes No
High Blood Pressure	Yes No	Parathyroid	Yes No	Angina	Yes No	Congenital Heart Disorder	Yes No
Heart Attack	Yes No	Kidney Problems	Yes No	Radiation Treatment	Yes No	Artificial Heart Valve	Yes No
Diabetes Type I	Yes No	Heart Failure	Yes No	Leukemia	Yes No	Rheumatic Fever	Yes No
Artificial Joint	Yes No	Diabetes Type II	Yes No	Heart Mumur	Yes No	Liver Disease	Yes No
Stroke	Yes No	Asthma	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Low Blood Pressure	Yes No	Thyroid Disease	Yes No	Blood Disease	Yes No	Epilepsy	Yes No
Hepatitis A	Yes No	Lung Disease	Yes No	Tuberculosis	Yes No	Cardiac Defibrillator	Yes No
Fainting or Dizzy Spell	Yes No	Hepatitis B	Yes No	Mitral Valve Prolapse	Yes No	Ulcers	Yes No
Cardiac Pacemaker	Yes No						

Any other serious illness not listed above? Yes No If yes

Are you currently taking a premedication for a condiditon listed above? Yes No If yes

Medications

Are you currently taking any medication? Yes No If yes

Are you currently taking a blood thinner? Yes No If yes

Allergies

Are you allergic to any of the following?

Latex	Yes No	Local Anesthestic	Yes No	Penicillin	Yes No	Aspirin	Yes No
Codeine	Yes No	Acrylic	Yes No	Metal	Yes No	Other	Yes No

Pleae list reaction: If yes

Women Only

Check all that apply:

Pregnant/Trying to get pregnant?	Yes No	Nursing	Yes No	Taking Oral Contraceptive	Yes No

Medical Doctors

Name of family medical doctor: If yes

Name of specialist (Cardiologist): If yes

Name of specialist (Orthopedic): If yes

Name of other specialist(s): If yes

Are you currently under a physcian's care? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Do you take, or have you ever taken, Phen-Fen or Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? Yes No If yes

Are you a tobacco user? Yes No If yes

Do you use controlled substances? Yes No If yes

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Office use only