1. HEALTH HISTORY - TCCDC

Today's Date

Patient Name____ Date of Birth: __________

Patient's Phone Number____

Has your address changed: Yes/No If yes, please write on the back of this form.

Personal Physician____

Clinic - Location__________________________ Phone: _______________

2. ALLERGIES

Please circle if you have any allergies to the following:

Amoxicilin	Aspirin	Erythromycin	Metals/Jewelry	Sulfa
Anesthestics	Codeine	Latex	Penicilin	Tetracycline

Other (explain)____

(If any circled) please describe symptoms: ____________________________

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3. COMMENTS / CHANGES

If there are any changes in your health history please explain

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4. MEDICATIONS

Please list any medications you are currently taking (include over the counter medicines) on the next page.

HEALTH INFORMATION

Date	No Changes	Patient Initials	Student Signature	Dentist Signature

3. CONDITIONS

Please circle if you have ever had any of the following disease or medical conditions.

- Alzheimer's / Memory Loss
- Anemia
- Anorexia / Bulimia
- Arthritis
- Artificial Joints (Date__________)
- Artificial Heart Valves
- Asthma / Hay Fever
- Blood Transfusions
- Cancer / Chemotherapy
- Cold Sores / Herpes
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug / Alcohol Abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Gastrointestinal Disorder/Acid Reflux
- Glaucoma (Narrow Angle)
- Headaches (Severe, Frequent)
- Hearing Impaired
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia / Abnormal Bleeding
- Hepatitis A B C D
- High / Low Blood Pressure
- HIV / AIDS
- Liver Disease
- Kidney Problems
- Mental Illness (type________________)
- Migraines
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatments
- Rheumatic / Scarlet Fever
- Shingles
- Smoking / Tobacco
- Sinus Problems
- Stents Placed in Heart (Date_______)
- Stroke
- Snoring / Sleep Apnea
- Tuberculosis
- Tumor Growth
- Venereal Disease
- Other / Surgeries
- **NONE OF THE ABOVE**

Have you ever been told you need antibiotics before a dentist appointment? ☐ Yes ☐ No

Are you pregnant/nursing?
☐ Yes ☐ No Due Date_____

Have you ever taken medication for osteoporosis?
(Ex. Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)
☐ Yes ☐ No
If yes, when did you start?_______

I certify that the above information is complete and accurate

Patient's /Guardian's Signature____ Date__________