HARBOR SQUARE DENTAL
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(425) 778-7477

Health History

Patients Name: _____Date of Birth_____
Physician's Name _____Physician's Phone# (___)_____
Please list all medications you are currently taking (including herbal/natural remedies):
_____
_____
Do you require antibiotics prior to a dental cleaning? **YES NO** Please list reason_____

Please circle if you have or have had any of the following:

HEART
Heart Attack
Heart Surgery
Heart Murmur
Mitral Valve prolapse
Congenital Heart Defects
Pacemaker/Defibrillator
Artificial heart valve
Angina/chest pain
High blood pressure
Low blood pressure
Rheumatic fever

BLOOD
Easy Bruising
Frequent nosebleeds
Abnormal bleeding
Blood Disease
History of blood transfusion

ALLERGY
Hay fever
Sinus problems
Skin rashes
Take allergy meds
Asthma

DIGESTIVE
Ulcers
Special diet
Constipation/diarrhea
Kidney Problems
Bladder Problems
Weight gain or loss
Acid Reflux

BONE/JOINT
Arthritis/ Rheumatoid
Back/Neck Pain
Joint replacement

NERVOUS SYSTEM
Seizures
Epilepsy
History of head injury
Other:

DIABETES
Type I
Type II
Family History of diabetes
Urinate more than 6x/day
Thirsty frequently
Controlled with medication

CANCER
Type:_____
Stage: I II III IV
In Remission
Chemotherapy

Other Conditions
Autoimmune disorder
Stroke
Thyroid disorder
Frequent/severe headaches
Eating disorder
Tuberculosis
Hepatitis A
Hepatitis B or C
Liver disease
Herpes or cold sores
Other STDs_____
HIV positive/ AIDS
Glaucoma
Alcoholism
Drug Addiction
Tobacco use
Behavioral Disorder
Special Needs Issues

Please list any other medical conditions you have ever had that are not listed above. _____
Have you been hospitalized for any reason within the last year? **YES NO** If yes please describe _____
_____

Do you have allergies to any of the following? Please circle:
Antibiotics Aspirin Barbiturates Codeine Iodine Latex Local Anesthetic Sulfa Other _____
Please describe your reaction: _____

WOMEN:
Are you pregnant? **YES NO** Due Date: _____ Are you nursing? **YES NO**
Are you taking birth control pills? **YES NO**
(Please note that some antibiotics may interfere with the effectiveness of birth control pills and a second form of birth control should be used If antibiotics are prescribed).

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature _____ Date _____

Provider Initials_____Date_____