HEALTH HISTORY

Dr. David M. Boyd, DMD

Today's Date:____/____/____ Birth Date:____/____/____ Age:________ Male_____ Female_____

First Name: ________________________ Last Name: ________________________

Your Physician's Name / Phone Number ________________________

Pharmacy Name / Phone Number ________________________

Are You, Or Have You Been Under A Physician's Care In The Past 2 Years? Yes _______ No _______

If Yes, For What? ________________________

List Any Medications Currently Taken: ________________________

____

Are You Allergic To Penicillin, Codeine Or Any Other Drug? Please List All Allergies:________________________

____

Circle Yes Or No To ALL The Conditions Below, You Are Being Treated For Or Have Had:

Asthma..............................Yes No
High Blood Pressure.........Yes No
Heart Murmur...................Yes No
Prolapsed Mitral Valve.....Yes No
Heart Attack......................Yes No
Heart Surgery / Date..........Yes No
Artificial Heart Valve.........Yes No
Angina...............................Yes No
Pacemaker..........................Yes No
Rheumatic Fever...............Yes No
Cancer...............................Yes No

Stroke.........................Yes No
Diabetes.....................Yes No
Artificial Joints..........Yes No
Kidney Disease..........Yes No
Liver Disease.............Yes No
Hepatitis....................Yes No
Type of Hepatitis ___________
Excessive Bleeding.....Yes No
Hemophilia................Yes No
Depression.................Yes No
Type of Cancer ________________________

Epilepsy..........................Yes No
Allergies...........................Yes No
HIV Infection...................Yes No
AIDS................................Yes No
Psychiatric Treatment.....Yes No

(Women)

Pregnant........................Yes No
Nursing.........................Yes No
Birth Control Pills........Yes No

Have You Had Any Serious Illness, Disease Or Condition Not Listed Above?..Yes No

If Yes, Explain: ________________________

Have You Ever Had Any Problems Or Anxiety Associated With Your Previous Dental Care?..............Yes No

If Yes, Explain: ________________________

Have You Ever Had Any Trouble With Excessive Bleeding After A Tooth Extraction?..........................Yes No

Have You Ever Had Any Unusual Reaction To Any Drug Or Local Anesthetic?.....................................Yes No

Last Dental Exam: ____________________ Is It Important To You To Keep Your Teeth?..............Yes No

What Concerns Do You Have About Your Dental Health? ________________________

To The Best Of My Knowledge, All Of The Preceding Answers Are True And Correct.
If I Have A Change In My Health, I Will Inform The Doctor At My Next Appointment.

Signature Of Patient, Parent Or Guardian: ________________________ Date:________________