HEALTH HISTORY

Name:_____ Date:_____

Phone #:_____Cell #:_____Email:_____

Date of last medical visit:_____ reason for visit:_____Date of last physical:_____

Any hospital visits in the last 5 yrs: date:_____ reason:_____

Do you have a history of any of the following (please circle all that apply):

Alzheimer's	COPD	HIV / AIDS	Seizures
Anemia	Diabetes	Hypertension	Sickle Cell Anemia
Arthritis	Dialysis	Kidney Disease	Sinus Problems
Artificial Joint/Implants	Emphysema	Leukemia	Smoker
Asthma	Epilepsy	Liver Disease	Stomach Disease
Back Problems	Glaucoma	Mouth Ulcers/Sores	Stroke
Blood Disease	Head Injuries	Pacemaker	Substance Abuse +/or Trtmt
Blood Thinners	Hearing Loss	Psychosis +/or Medication	Thyroid Disease
Cancer	Heart Attack	Respiratory Disease	Transplants
Cancer Treatment Active	Heart Disease	Rheumatic Fever	Tuberculosis
Communicable Disease	Hepatitis A B C	Rheumatism	Tumors

Are you pregnant? **Yes no** Do you take birth control? **Yes No**

List all medications you are taking (prescriptions and over the counter):

_____ _____ _____

_____ _____ _____

Do you have any allergies? Aspirin Acetaminophen Clindamycin Codeine Erythromycin Epinephrine Hydrocodone Ibuprofen Latex Penicillin Tetracycline Metal Other_____

Do you use tobacco products? Type_____ amount_____

Is there any other information we should know to better assist you?_____

DENTAL HISTORY

Name of former dentist:_____Date of last visit:_____

Do you have a specific dental problem?_____

Are you required to take antibiotics before your dental visits? **Yes No**

Do you like your smile? **Yes No** Do your gums bleed **Yes No** Do you have decay? **Yes No**

Do you have joint noise or pain? **Yes No** Do clench or grind? **Yes No**

Please add anything you want the Dr to know: _____

I understand that Michael Krone DDS/John Peroutka DDS will keep this information confidential, it's only use is to better treat me. I have answered all these questions to the best of my knowledge and have not withheld any information.

Patient signature: _____ Date: _____

Dr Name: _____ Dr signature: _____ Date: _____