WestcoastSmile
Dental Studio and Whitening Spa

HEALTH HISTORY

Please check YES or NO to each question

Date: _____ Patient Name: _____

1. Are you being treated for any medical condition at present or within the past year? If yes, please explain?	Yes ☐ No ☐
2. Have there been any changes in your general health in the past year?	Yes ☐ No ☐
3. When was your last visit to a physician?	When was your last complete physical examination?
4. List any PRESCRIPTIONS and NON-PRESCRIPTION medications you are taking or have recently taken (including birth control pills)	
5. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin or other antibiotics, aspirin, codeine, local anesthetic "dental freezing")? Please explain:	Yes ☐ No ☐
6. Have you ever been advised against taking any specific type of medication?	Yes ☐ No ☐
7. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?	Yes ☐ No ☐
8. Have you ever fainted during a dental or medical treatment?	Yes ☐ No ☐
9. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Please explain:	Yes ☐ No ☐
10. Are you on cortisone or steroid therapy? or, are you on a diet pill therapy?	Yes ☐ No ☐
11. Do you have any artificial joints (e.g. hip, knee)?	Yes ☐ No ☐
12. Have you ever been advised to take antibiotics before dental treatment?	Yes ☐ No ☐
13. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever?	Yes ☐ No ☐
14. Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)? Please explain:	Yes ☐ No ☐
15. Do you have, or have you ever had, any chest pain, shortness of breath or any heart palpitation without exertion?	Yes ☐ No ☐
16. Are you presently suffering from any infectious diseases?	Yes ☐ No ☐
17. Do you have any conditions that could affect your immune system (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)? Please explain:	Yes ☐ No ☐

19. Indicate which of the following you presently have, or ever had: (Please check all that apply)

Asthma ☐	Epilepsy or Seizures ☐	Tuberculosis ☐	Glandular Disorders ☐
Bronchitis ☐	Hepatitis ☐	Diabetes ☐	Organ Transplant/Medical Implant ☐
Emphysema ☐	Jaundice ☐	Kidney Disease ☐	Stomach/Intestinal Problems ☐
Lung Disease ☐	Liver Disease ☐	Thyroid Disease ☐	Ulcers ☐

20. Do you, or did you smoke?	Yes ☐ No ☐
Do you drink alcoholic beverages on a regular basis?	Yes ☐ No ☐
Do you use recreational drugs?	Yes ☐ No ☐
21. WOMEN ONLY: Are you pregnant? Yes ☐ No ☐	If pregnant, delivery date? _____ Are you breast feeding? Yes ☐ No ☐
22. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?	Yes ☐ No ☐
23. Do you currently have, or ever had in the past, any disease, condition or problem not listed above?	Yes ☐ No ☐

Signature: _____