Time 3:15 PM | Ronald M Harrell, DMD | Date 1/3/2023

HEALTH HISTORY UPDATED 02/2022

Patient Name: | Birth Date: | Date Created:

MEDICAL CONDITONS:	◯ Yes ◯ No	If yes
ALLERGIES:	◯ Yes ◯ No	If yes
MEDICATIONS:	◯ Yes ◯ No	If yes

Are you under a physician's care now? If yes Please list name and phone numer.	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you required to pre-med with antibiotcs before dental treatment?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use alcohol?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Are you pregnant or planning to become pregnant?	◯ Yes ◯ No	If yes
Have you ever had an allergic reaction?	◯ Yes ◯ No	If yes

Do you have a history or being treated for any Digestive conditions?	◯ Yes ◯ No	If yes
Do you have a history or being treated for any Heart or Circulatory conditions?	◯ Yes ◯ No	If yes
Do you have a history or being treated for any Neurological conditions?	◯ Yes ◯ No	If yes
Do you have a history or being treated for any Lung or Breathing conditions	◯ Yes ◯ No	If yes
Do you have a history or being treated for any Autoimmune conditions?	◯ Yes ◯ No	If yes

Please check all conditions that you have history of or are currently being treated for

Head or neck Injuries	◯ Yes ◯ No	tumor or abnormal growth	◯ Yes ◯ No	Osteoporosis/Osteopenia	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Radiation therapy	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Tuberculosis/Measles/chicken pox	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
History of Cancer	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No

Please check all medications you are currently taking

Are you taking any Antidepressants or Anxiety medications?	◯ Yes ◯ No	If yes
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications	◯ Yes ◯ No	If yes
Are you taking any pain medications?	◯ Yes ◯ No	If yes
Are you taking any Allergy or Asthma medications?	◯ Yes ◯ No	If yes
Are you currently taking any other medications or dietary supplements?	◯ Yes ◯ No	If yes
Are you taking any Antibiotics?	◯ Yes ◯ No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____