PAUL HORTON, DMD, PA

HEALTH HISTORY

Patient Name: ____Date_____________________

How would you rate your medical health? Good ______ Fair ______ Poor ______

How would you rate your dental health? Good ______ Fair ______ Poor ______

Physician's Name ____

Last Complete Physical ____

Are you allergic to: Penicillin____ Codeine____ Local Anesthetic____ Latex____ Other____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? Yes___No___

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS

Bisphophonate: Yes___No___ Coumadin/Plavix: Yes___No___ Daily Aspirin: Yes___No___

Do you now have or have you ever had any of the conditions listed below (check YES or NO)

Condition		Condition	
Abnormal Blood Pressure	Yes___No___		
Anemia	Yes___No___	Joint Replacement	Yes___No___
Arthritis	Yes___No___	Hip___Date_____Knee____Date______	
Asthma	Yes___No___	Pacemaker	Yes___No___
Bleeding Problems	Yes___No___	Prosthetic Heart Valve	Yes___No___
Blood Diseases	Yes___No___	Radiation Treatment	Yes___No___
Cancer	Yes___No___	Respiratory Problems	Yes___No___
Diabetes	Yes___No___	Seizures	Yes___No___
Emphysema	Yes___No___	Stroke/TIA's	Yes___No___
Glaucoma	Yes___No___	Thyroid Problems	Yes___No___
Heart Disease	Yes___No___	Transplant Patient	Yes___No___
Hepatitis A, B, or C	Yes___No___	Tuberculosis	Yes___No___
HIV Positive/Aids	Yes___No___	Tumors/Biopsies	Yes___No___

(WOMEN ONLY) Are you currently pregnant? Yes___No___ How far along? ___________

OFFICE USE ONLY:

Updated: ____________________Date_________________

Updated: ____________________ Date_________________

Updated: _____________________Date________________