Boyle DENTISTRY

Health Information

Patient Name _____

Have you had any of the following? *Please check those that apply:*

□ AIDS / HIV+	□ Hay Fever	□ Pacemaker	□ Please list any other
□ Anemia	□ Heart Defect	□ **Pregnancy** Due:	Health related conditions:
□ Arthritis	□ Heart Disease	□ Radiation Treatment	_____
□ Artificial Joints	□ Heart Murmur	□ Respiratory Problems	_____
□ Asthma	□ Hepatitis	□ Rheumatic Fever	_____
□ Cancer	□ High Blood Pressure	□ Sinus Problems	_____
□ Diabetes	□ Kidney Disease	□ Stroke	_____
□ Excessive Bleeding	□ Liver Disease	□ Tuberculosis	_____
□ Fainting	□ Mental Disorders	□ Ulcers	_____
□ Glaucoma	□ Nervous Disorders	□ Venereal Disease	_____

Comments:_____

MEDICATIONS (**Please List ALL**):_____

_____

Are you **ALLERGIC** to or have had a bad reaction to:

□ Local Anesthetic (Novocain, etc.) □ Latex □ Penicillin □ Codeine □ Metals

Other Allergies: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No

If yes, please explain: _____

Name of physician: _____ Phone: _____

Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain: _____

_____

In case of emergency contact: _____

name phone #

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

*_____ Date: _____ _____ Date:_____

Signature of patient, parent, or guardian Doctor Signature

Updates:

Date	Patient Signature	Changes in Above information	Dr. Signature