HEALTH HISTORY

Dr. David M. Boyd, DMD

Today's Date:___/___/___ Birth Date:___/___/___ Age:_____ Male____ Female____

First Name: _____ Last Name: _____

Your Physician's Name / Phone Number _____

Pharmacy Name / Phone Number _____

Are You, Or Have You Been Under A Physician's Care In The Past 2 Years? Yes _____ No _____

If Yes, For What? _____

List Any Medications Currently Taken: _____

_____

Are You Allergic To Penicillin, Codeine Or Any Other Drug? Please List All Allergies:_____

_____

Circle Yes Or No To ALL The Conditions Below, You Are Being Treated For Or Have Had:

Asthma	Yes	No	Stroke	Yes	No	Epilepsy	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No	Allergies	Yes	No
Heart Murmur	Yes	No	Artificial Joints	Yes	No	HIV Infection	Yes	No
Prolapsed Mitral Valve	Yes	No	Kidney Disease	Yes	No	AIDS	Yes	No
Heart Attack	Yes	No	Liver Disease	Yes	No	Psychiatric Treatment	Yes	No
Heart Surgery / Date	Yes	No	Hepatitis	Yes	No			
Artificial Heart Valve	Yes	No	Type of Hepatitis _____			(Women)		
Angina	Yes	No	Excessive Bleeding	Yes	No	Pregnant	Yes	No
Pacemaker	Yes	No	Hemophilia	Yes	No	Nursing	Yes	No
Rheumatic Fever	Yes	No	Depression	Yes	No	Birth Control Pills	Yes	No
Cancer	Yes	No	Type of Cancer _____					

Have You Had Any Serious Illness, Disease Or Condition Not Listed Above? Yes No

If Yes, Explain: _____

Have You Ever Had Any Problems Or Anxiety Associated With Your Previous Dental Care? Yes No

If Yes, Explain: _____

Have You Ever Had Any Trouble With Excessive Bleeding After A Tooth Extraction? Yes No

Have You Ever Had Any Unusual Reaction To Any Drug Or Local Anesthetic? Yes No

Last Dental Exam: _____ Is It Important To You To Keep Your Teeth? Yes No

What Concerns Do You Have About Your Dental Health? _____

To The Best Of My Knowledge, All Of The Preceding Answers Are True And Correct.
If I Have A Change In My Health, I Will Inform The Doctor At My Next Appointment.

Signature Of Patient, Parent Or Guardian: _____ Date:_____