Dodi Nov, DDS
Cosmetic & General Dentistry

Health History

Patient name

1. Have you been under the care of a physician during the past two years? ◯ Yes ◯ No If yes, for what?

Physician's name | Phone

Address | City | State | Zip

2. Have you taken any medications or drugs during the past two years? ◯ Yes ◯ No
3. Are you taking any medications, pills, or drugs now? ◯ Yes ◯ No If yes, please list name and dosage

Name/Dosage | Name/Dosage
Name/Dosage | Name/Dosage
Name/Dosage | Name/Dosage

4. Are you aware of having any allergic (or adverse) reaction to any medication or substance? ◯ Yes ◯ No

If yes, please list/explain

5. Have you been in a hospital for treatment in the past 5 years? ◯ Yes ◯ No

If yes, please list/explain

6. Indicate which of the following you have had, or have at the present. Select "Y" for yes or "N" for no on each item.

Condition			Condition			Condition		
Heart (surgery,disease,attack)	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No	A.I.D.S.	◯ Yes	◯ No
Chest pain	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	HIV positive	◯ Yes	◯ No
Congenital heart disease	◯ Yes	◯ No	Thyroid problems	◯ Yes	◯ No	Cold sores	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No
High blood pressure	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	Sickle cell disease	◯ Yes	◯ No
Mitral valve prolapse	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No	Liver disease	◯ Yes	◯ No
Artificial heart valve	◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No	Latex sensitivity/allergy	◯ Yes	◯ No	Neurological disorders	◯ Yes	◯ No
Arthritis/rheumatism	◯ Yes	◯ No	Allergies or hives	◯ Yes	◯ No	Epilepsy or seizures	◯ Yes	◯ No
Cortisone medicine	◯ Yes	◯ No	Sinus troubles	◯ Yes	◯ No	Fainting or dizzy spells	◯ Yes	◯ No
Stroke	◯ Yes	◯ No	Radiation therapy	◯ Yes	◯ No	Nervous/anxious	◯ Yes	◯ No
Diet (special/restricted)	◯ Yes	◯ No	Chemotherapy	◯ Yes	◯ No	Panic attacks	◯ Yes	◯ No
Artificial joints (hip, knee, etc.)	◯ Yes	◯ No	Tumors	◯ Yes	◯ No	Psychiatric/psychological care	◯ Yes	◯ No
Kidney trouble	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Metal allergies/reactions	◯ Yes	◯ No

7. Do you have or have you had any disease, condition, or problem not listed?____________________

8. Women: Are you pregnant? ◯ Yes, _____months ◯ No Nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/guardian signature | Date | Dr. Nov's signature after review | Date

(Doctor use only) Antibiotics rxn discussed