

HEALTH HISTORY

Orvis J. R. Johnson, D.D.S. • 825 Prospect Ave. • North Fond du Lac, WI 54937

Patient Name _____ Date _____

Have you been or are you now under a physician's care?Yes No

If yes, why?Yes No

Have you ever been hospitalized?Yes No

Reason: _____

Physician's Name: _____

When was your last complete physical? _____

Are you currently taking any medications? _____

List: _____

Have you taken any cortisone/had any steroid therapy during the past two years?Yes No

Are you allergic to or have any adverse reaction to any of the following medications:

Aspirin	Codine	Penicillin
Erythromycin	Local Anesthetic	Nitrous Oxide

Are you aware of being allergic to any other medications?Yes No

If yes, please List: _____

Do you have or have you had any of the following:

Artificial JointYes	No	AnemiaYes	No
Heart Valve implantYes	No	Blood TransfusionYes	No
Heart Disease/AttackYes	No	Hepatitis/Jaundice/Liver DiseaseYes	No
Rheumatic FeverYes	No	TuberculosisYes	No
Heart MurmurYes	No	AIDS/HIV ExposureYes	No
High/Low Blood PressureYes	No	Venereal DiseaseYes	No
PacemakerYes	No	Alcoholism/Drug AbuseYes	No
Allergies/AsthmaYes	No	Radiation TreatmentYes	No
Sinus ProblemsYes	No	Cancer/TumorYes	No
Epilepsy/SeizuresYes	No	ChemotherapyYes	No
Fainting/Dizzy SpellsYes	No	Malignant Hyperthermia/Family HistoryYes	No
Psychiatric TreatmentYes	No	UlcersYes	No
GlaucomaYes	No	Nervous ProblemsYes	No
DiabetesYes	No	Recent Weight LossYes	No
Eating DisorderYes	No	Blood DiseasesYes	No
Circulatory ProblemsYes	No	ArthritisYes	No
Excessive Bleeding from Cut/InjuryYes	No	StrokeYes	No

Do you smoke or chew tobacco?Yes No

How Much: _____

Do you consume alcoholic beverages?Yes No

How Often: _____

Are you pregnant or suspect you may be?Yes No

Are you nursing?Yes No

Are you taking oral contraceptives?Yes No

Do you wear contact lenses?Yes No

Do you have any disease, condition or problem not listed?Yes No

To the very best of your knowledge, the above information is accurate and true:

Patient Signature: _____ Date: _____

Staff Signature: _____ Dr. Initial: _____

