KIRSCH FAMILY DENTISTRY

18 E. WASHINGTON ST.
GREENCASTLE, IN 46135
P: (765) 653-8615
F: (765) 653-5227

HEALTH HISTORY

(Please Print in Blue or Black Ink)

Date _____

First Name _____ Middle Initial_____ Last Name_____

Preferred Name _____ Email _____

Best Contact Number (___)_____ *Please notify us if address has changed

Physician Name _____ Physician Phone # (____) _____

I consider my health to be (please circle): **E**xcellent **G**ood **F**air

Do you have/or have had any of the following? *Please Circle Y for yes and N for no.*

1.	**Y**	**N**	Heart Attack	20.	**Y**	**N**	Diabetes
2.	**Y**	**N**	Stroke	21.	**Y**	**N**	Problems with immune system
3.	**Y**	**N**	Artificial Heart Valve	22.	**Y**	**N**	Infectious Mononucleosis
4.	**Y**	**N**	Mitral Valve Prolapse	23.	**Y**	**N**	Herpes
5.	**Y**	**N**	Cardiac Pacemaker	24.	**Y**	**N**	Arthritis
6.	**Y**	**N**	Defibrillator	25.	**Y**	**N**	Kidney Disease/dialysis
7.	**Y**	**N**	Irregular heartbeat	26.	**Y**	**N**	Thyroid disease hypo / hyper
8.	**Y**	**N**	High / Low Blood Pressure	27.	**Y**	**N**	Anxiety/depression
9.	**Y**	**N**	Heart Surgery	28.	**Y**	**N**	Cancer, Tumor or Malignancy
10.	**Y**	**N**	Blood Thinner	29.	**Y**	**N**	Chemotherapy/Radiation
11.	**Y**	**N**	Abnormal bleeding tendency	30.	**Y**	**N**	History of Drug Addiction
12.	**Y**	**N**	Anemia	31.	**Y**	**N**	HIV/AIDS
13.	**Y**	**N**	Tuberculosis or Lung Disease	32.	**Y**	**N**	Immune Suppressed Disorder
14.	**Y**	**N**	Asthma/Hay Fever	33.	**Y**	**N**	Hearing Loss
15.	**Y**	**N**	COPD/emphysema/difficulty breathing	34.	**Y**	**N**	Fainting Spells
16.	**Y**	**N**	Sinus Trouble	35.	**Y**	**N**	Glaucoma
17.	**Y**	**N**	Epilepsy/ Seizures	36.	**Y**	**N**	Emotional/Nervous Disorder
18.	**Y**	**N**	Liver Disease/Jaundice/Hepatitis ___	37.	**Y**	**N**	Osteoporosis/bisphosphonates
19.	**Y**	**N**	Stomach Ulcers/ G.E.R.D/ Acid Reflux	38.	**Y**	**N**	Artificial Joint
							□ Knee □ Hip □ Shoulder □ Other_____

NOTES:

- Do you usually take an antibiotic prior to receiving dental treatment? □ Yes □ No
- Do you smoke or use tobacco products? □ Yes □ No How many years? _____
- Have you had any illness, operation or been hospitalized in the past 5 years? □ Yes □ No
  If yes, please list procedures and dates:
  _____

Please list ALL medications (prescribed or OTC) you are currently taking: *or please provide us with a list*

Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____

Medication_____ Reason_____

ALLERGIES **Are you allergic to or had a reaction to:**	
Y N Penicillin Y N Sulfa Drugs/Sulfites/Sulfides Y N Other Antibiotics Y N Local Anesthetics Y N Latex	Y N Aspirin Y N Ibuprofen Y N Codeine Y N Other narcotics/pain medications Y N Other_____
Please describe reaction:	

Women: Are you pregnant? **Y N** If yes, Due Date: _____
Are you currently nursing? **Y N**
Are you taking birth control medications? **Y N**

Have you ever had a reaction to Dental Treatment/s? **Y N**
If yes, Explain: _____

Have you ever had a complication or illness following dental treatment? **Y N**
If yes, Explain: _____

Is there anything in your medical/dental history that you feel our office should be aware of? **Y N**
If yes, Explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above are answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions I have made in the completion of this form.

Signature _____ Date _____

Printed Name_____ Relationship _____
(if patient is a minor)