Dr. Justin Poff
7041 Hwy 70 South, Suite 7
(615) 662-2400
poffdentalassociates.com

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Physician phone number	
Date of last physical exam	
Have you ever been hospitalized for an injury or illness?	
Have you ever had a serious head or neck injury?	
Do you or have you ever taken Phen-Fen or Redux?	
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	
Are you on a special diet?	
Do you use or have you ever used tobacco?	
Do you use controlled substances?	
Have you ever been advised that you require antibiotics prior to dental treatment?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you currently taking oral contraceptives?	
Are you allergic to any of the following?	
Do you experience any anxiety when coming to the dentist?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for

AIDS/HIV Positive	
Alzheimer's Disease	
Anaphylaxis	
Anemia	
Arthritis/Gout	
Artificial Heart Valve	
Artificial Joint	
Asthma	
Blood Disease	
Blood Transfusion	
Breathing Problems	
Bruise Easily	
Cancer	
Chemotherapy	
Chest Pains	
Cold Sores/Fever Blisters	
Congenital Heart Disorder	
Convulsions	
Cortisone Medicine	
Diabetes	
Drug Addiction	
Easily Winded	
Emphysema	
Epilepsy or Seizures	
Excessive Bleeding	
Excessive Thirst	
Fainting Spells/Dizziness	
Frequent Cough	
Frequent Diarrhea	
Glaucoma	
Hay Fever	
Heart Attack/Failure	
Heart Murmur	
Heart Pacemaker	
Heart Trouble/Disease	
Hemophilia	
Hepatitis A	
Hepatitis B or C	
Herpes	
High Blood Pressure	
High Cholesterol	
Hives or Rash	

Hypoglycemia	
Irregular Heartbeat	
Kidney Problems	
Leukemia	
Liver Disease	
Lung Disease	
Low Blood Pressure	
Mitral Valve Prolapse	
Osteoporosis	
Pain in Jaw Joints	
Parathyroid Disease	
Psychiatric Care	
Radiation Treatments	
Recent Weight Loss	
Renal Dialysis	
Rheumatic Fever	
Rheumatism	
Scarlet Fever	
Shingles	
Sickle Cell Disease	
Sinus Trouble	
Spina Bifida	
Stomach/Intestinal Disease	
Stroke	
Swelling of Limbs	
Thyroid Disease	
Tonsillitis	
Tuberculosis	
Tumors/Growths	
Ulcers	
Venereal Disease	
Yellow Jaundice	
Have you ever had any serious illness not listed above?	

Patient's signature: Date:

Doctor's signature: Date: