Print Form

FAMILY CARE DENTISTRY

Yearly Health History

Patient's Name: _____ Date of Birth: _____

Physicians Name & Number: _____

List all Allergies:

List all Medications:

Have you had any recent surgeries?

Any artificial joints, or artificial heart valve, or history of ineffective endocarditis?

Have you or are you taking any bone density medications? If so, which one and how long?

Signature: _____ Date: _____