HEALTH HISTORY FORM

Name (First and Last) _____ DOB _____

Mailing Address _____ Phone Number _____

City, State, Zip Code _____ Alternate Number _____

Treating Doctor (Name and Location) _____ Physicians Phone Number _____

ALLERGY HISTORY

List any drug allergies: _____ Reactions: _____

Allergies to materials or food: _____ Reactions:_____

Photosensitivity or Solar Urticaria Yes or No

CURRENT MEDICATIONS: _____

_____

_____

SURGICAL OR HOSPITALIZATION HISTORY: _____

_____

_____

MEDICAL CONDITIONS:

Yes	No	Anemia/Sickle Cell/Other	Yes	No	Epilepsy/Seizures
Yes	No	Asthma	Yes	No	Heart disease
Yes	No	Lung disease	Yes	No	Hepatitis
Yes	No	Bleeding problem	Yes	No	High blood pressure
Yes	No	Blood clots	Yes	No	High Cholesterol
Yes	No	Cerebral palsy	Yes	No	Arthritis
Yes	No	Crohn's disease	Yes	No	Thyroid problems
Yes	No	Diabetes	Yes	No	Tuberculosis

HEALTH HISTORY FORM

Continued:

_____ _____

Name (First and Last) DOB

Please list any other medical conditions or information that we should know (i.e. dementia, pregnant): _____

_____

_____

Please describe your current diagnosis and current treatment plan. The more detailed information we have, the better we can customize your treatment plan, resulting in successful prevention of oral mucositis (i.e. radiation + chemo, chemo only, surgeries) : _____

_____

_____

_____

_____

_____

READ, INITIAL, AND SIGN BELOW:

_____ I understand that the services are not covered by dental or medical insurance. I accept personal responsibility for the payment of incurred charges at the time services are rendered.

_____

I have personally supplied the above information and attest that it is true and complete to the best of my knowledge.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible party if different from patient Date