HEALTH HISTORY
Dr. Rod Maxfield, DDS

Name _____ Date of Birth _____

Physician's Name _____ Physician's Phone _____

1. Are you now or have you been UNDER MEDICAL CARE within the last year? . . . . . Yes No
   If yes, please explain _____

2. Are you taking ANY DRUGS or MEDICATIONS? CIRCLE all that apply.
   Antidepressants Blood pressure Heart medications Hormones Steroids Insulin
   Antibiotics Blood thinners Pain medications Birth control Herbs Others
   Please LIST names and purpose of medications _____

3. Do you use tobacco (smoke, chew)? Y N If yes, are you interested in quitting? Yes No
4. Are you alcohol or drug dependent? Y N
5. Have you ever taken Phen-fen? Y N
6. Women Only: Are you PREGNANT? Y N Maybe Due Date _____

7. Do you have, or have you ever had, any of the following? CIRCLE all that apply & EXPLAIN below
   - Artificial heart valves, Stents or Joint replacements _____
   - Rheumatic fever / Heart attack, Murmur or Heart condition _____
   - High blood pressure or Stroke _____
   - Low blood pressure or Fainting _____
   - Asthma / Lung / Respiratory condition _____
   - Arthritis / Rheumatism _____
   - Diabetes / High or Low blood sugar _____
   - Prolonged bleeding / Clotting or Bruising problems _____
   - Tuberculosis / persistent Cough or cough that produces blood _____
   - Hepatitis, Liver or Kidney problems _____
   - HIV Positive or high risk lifestyle _____
   - Venereal disease / STD _____
   - Epilepsy / Seizures _____
   - Depression / Mental conditions / Hyperactivity _____
   - Nervous conditions or Psychiatric treatment? _____
   - Pain in the face, head, neck or jaws (TMJ) _____
   - Bleeding or Sensitive gums? _____

8. Are you ALLERGIC to or have difficulty with any drugs, metals, anesthetics, latex or others? Y N
   If yes, please explain _____

9. Have you ever had ANY DIFFICULTY with DENTAL TREATMENT or local anesthetics? Y N
   If yes, please explain _____

10. How do you feel about the APPEARANCE of your teeth? _____

11. Are any of your teeth in PAIN or sensitive to cold, hot, sweets, or pressure? Circle all that apply.

12. Please describe YOUR dental CONCERNS: _____

Doctor's notes _____

Patient SIGNATURE _____ Date _____
(by parent or guardian if 17 or younger)

Updated Date _____ _____ _____ _____
Patient Signature _____ _____ _____ _____