Anthony W. Boe, DDS
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Phone (952) 475-0989
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HEALTH INFORMATION

Date of Birth ____________ Sex ❑M ❑F

Patient ______________________________________ Preferred/Nickname ______________________

Whom may I notify in case of an emergency: ____

Phone ______________________________________ Relationship to you ______________________

Name of Physician ____________________________ Phone _________________________________

Clinic or Facility Name ____

Pharmacy Name ______________________________ Phone _________________________________

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING: (Please check Yes or No)

❑YES ❑NO Arthritis
❑YES ❑NO Hip/Joint Replacement ____________
❑YES ❑NO High Blood Pressure
❑YES ❑NO Low Blood Pressure
❑YES ❑NO Radiation or Chemical Therapy
❑YES ❑NO Diabetes _________________ ❑I ❑II
❑YES ❑NO Hepatitis _____________ type
❑YES ❑NO Ulcers ________________________
❑YES ❑NO Hemophilia, Bleeding or Blood Disorder
❑YES ❑NO Epilepsy, Seizures
❑YES ❑NO Enzyme Deficiency (I.E.) G6PD
❑YES ❑NO Anemia, Sickle Cell Disease
❑YES ❑NO Acquired Immune Deficiency Syndrome (HIV)
❑YES ❑NO Heart Murmur/Heart Problems

❑YES ❑NO Thyroid Condition
❑YES ❑NO Venereal Disease
❑YES ❑NO Kidney Disorder
❑YES ❑NO Pacemaker (type) __________
❑YES ❑NO Rheumatic Fever
❑YES ❑NO Allergy _______________
❑YES ❑NO Fainting Spells
❑YES ❑NO Latex Sensitivity
❑YES ❑NO Chronic Diarrhea
❑YES ❑NO Chronic Sinus
❑YES ❑NO Asthma or Hay fever
❑YES ❑NO Tuberculosis
❑YES ❑NO Chemical Dependency Treatment
❑YES ❑NO Anorexia, Bulimia
❑YES ❑NO Blood Transfusion

❑YES ❑NO Pre-medicaton for Dental Treatment Operation/Surgical
❑YES ❑NO Have you ever had an allergic reaction or been told not to take any medication?
If yes, describe: ____
❑YES ❑NO Are you currently taking any prescription drug of any kind?
(Ex: birth control, hormone, diet). If yes, what? ______________________________
❑YES ❑NO Are you currently taking any non-prescription drugs of any kind?
(*Ex: aspirin, cough syrup, nasal spray, recreational drug use, high caffeine intake)*
If yes, What? ____

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❑YES ❑NO Are you pregnant?
If yes, anticipated delivery date _______________ Are you nursing? ❑YES ❑NO

❑YES ❑NO Do you use tobacco? *If yes, daily intake* ____

❑YES ❑NO Do you wear contact lenses?

❑YES ❑NO Do you have any disease, condition or problem not listed that we should know about?
If yes, explain ____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE ____________________________________ DATE ____________________________________
Patient or Guardian of Minor

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SIGNATURE ____________________________________ DATE ____________________________________
Patient or Guardian of Minor

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SIGNATURE ____________________________________ DATE ____________________________________
Patient or Guardian of Minor

Please fill out new health form every three years