HEALTH HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

Yes / No Is your general health good? If no, explain _____

Yes / No Has there been a change in your health within the last year? If yes explain _____

Yes / No Have you been hospitalized or had a serious illness in the last three years? If yes, explain _____

Yes / No Are you being treated by a physician now? If yes, explain _____ Date of last medical exam _____

Yes / No Have you had problems with prior dental treatment?

If yes, please explain: _____ Date of last dental exam _____

Current weight: _____ lbs.

HAVE YOU EXPERIENCED?

Yes / No Chest pain (angina)?
Yes / No Swollen ankles?
Yes / No Shortness of breath?
Yes / No Recent weight loss, fever, night sweats?
Yes / No Persistent cough, coughing up blood?
Yes / No Bleeding problems, bruising easily?
Yes / No Difficulty swallowing?
Yes / No Diarrhea, constipation, blood in stools?
Yes / No Dizziness?
Yes / No Ringing in ears?
Yes / No Headaches?
Yes / No Fainting spells?
Yes / No Blurred vision?
Yes / No Seizures?
Yes / No Frequent vomiting, nausea?
Yes / No Joint pain, stiffness?
Yes / No Jaundice?
Yes / No Dry mouth?
Yes / No Frequent urination?
Yes / No Excessive thirst?
Yes / No Sinus problems?
Yes / No Difficulty urinating, blood in urine

DO YOU HAVE OR HAVE YOU HAD? (IF MULTIPLE CHOICES, PLEASE CIRCLE ALL THAT APPLY)

Yes / No Heart disease?
Yes / No Heart attack, heart defects?
Yes / No Arthritis, rheumatism?
Yes / No Rheumatic fever?
Yes / No Stroke, hardening of arteries?
Yes / No Psychiatric care
Yes / No Radiation treatments
Yes / No Artificial joint
Yes / No Thyroid, adrenal disease?
Yes / No Asthma, TB, emphysema, other lung diseases?
If yes, please specify:_____
Yes / No AIDS/HIV
Yes / No Tumors, cancer?
Yes / No Eye diseases?
Yes / No Anemia?
Yes / No Kidney, bladder disease?
Yes / No Hospitalization
Yes / No Blood transfusions
Yes / No Pacemaker/Prosth. heart valve
Yes / No High blood pressure?
Yes / No Hepatitis, other liver disease?
If yes, please specify:_____
Yes / No Diabetes?
Yes / No Heart murmurs?
Yes / No Skin diseases?
Yes / No Venereal disease
Yes / No Herpes?
Yes / No Chemotherapy
Yes / No Contact lenses
Yes / No Surgeries
Yes / No Stomach problems, ulcers?
Yes / No Family history of diabetes, heart problems, tumors?

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

Yes / No Aspirin
Yes / No Darvon
Yes / No Codeine
Yes / No Percodan
Yes / No Latex
Yes / No Local Anesthetic
Yes / No Valium
Yes / No Vicodin
Yes / No Demerol
Yes / No Penicillin
Yes / No Sulfa
Yes / No Tetracycline
Yes / No Erythromycin
Yes / No Nitrous Oxide
Yes / No Metal (Please specify below)

Others: _____

ARE YOU TAKING?

Yes / No Recreational drugs?
Yes / No Tobacco in any form?
Yes / No Alcohol?
Yes / No Bisphosphonate?
Yes / No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?

Please list: _____

WOMEN ONLY:

Yes / No Are you or could you be pregnant or nursing?
Yes / No Taking birth control pills?

ALL PATIENTS:

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

_____ _____ _____ _____

Physician's Name | Phone Number | Signature | Date

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____ See Clinical Notes _____

Signature | Date | Doctor's signature | Date