Health History

Patient Name: _____ Date: _____

CIRCLE APPPROPRIATE ANSWER: Leave blank if you do not understand the question.

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health in the last year?
3. Yes No Have you been hospitalized, or had a serious illness in the last 3 years? If yes, why? _____
4. Yes No Are you being treated by a physician now? For what? _____ Date of last medical exam? _____ Date of last dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

HAVE YOU EXPERIENCED:

7. Yes No Chest Pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred Vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry Mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart Disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung disease?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: Foods, medications, latex?
39. Yes No Family history of diabetes, tumors?
40. Yes No AIDS/HIV
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin disease?
45. Yes No Anemia?
46. Yes No STD?
47. Yes No Herpes?
48. Yes No Kidney?
49. Yes No Thyroid disease?
50. Yes No Diabetes?

DO YOU HAVE OR HAVE YOU EVER HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatment?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood Transfusion?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

ARE YOU TAKING:

61. Yes No Recreational Drugs
62. Yes No Medications, Over the counter drugs, herbal supplements, vitamins?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please List medications:

_____

_____

WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?

66. Yes No Taking birth control pills?

ALL PATIENTS:

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

If so, please explain:

_____

_____

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

Patients signature: _____ Date: _____

RECALL REVIEW:

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____

Patients signature: _____ Date: _____