HEALTH HISTORY

PATIENT NAME: _____

Circle the appropriate answer:

Yes No Is your general health good?
Yes No Has there been a change in your health with in the last year?
Yes No Have you been hospitalized or had a serious illness, or surgeries in the last 3 yrs?
If yes, why? _____
Yes No Are you being treated by a physician now? For what? _____
_____
Date of last Medical Exam: _____ Last Dental Exam: _____
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?

Circle all that you have experienced:

Anemia
Arthritis, rheumatism
Artificial Joint
Aspirin Allergy
Asthma
Bleeding Problems
Blood Transfusion
Blurred Vision
Bruising Easily
Chemotherapy
Chest Pain
Codeine Allergy
Diabetes
Diarrhea, constipation
Difficulty Swallowing
Difficulty Urinating
Dizziness
Dry Mouth
Excessive Thirst
Eye Disease
Fainting Spells
Fam His. Of Diabetes
Fam.His. of Tumors
Food Allergies
Frequent Urination
Headaches
Heart Attack
Heart Disease
Heart Murmur, Defect
Hepatitis
Herpes
High Blood Pressure
HIV/AIDS
Jaundice
Jaw Joint Pain
Joint Pain, stiffness
Kidney/bladder Disease
Latex Allergy
Lung Disease
Medication Allergy
Other
Pacemaker
Penicillin Allergy
Persistent Cough
Pre-med
Pros. Heart Valve
Psychiatric Treatment
Radiation Treatment
Rheumatic Fever
Ringing In Ears
Seizures
Shortness of Breath
Sinus Problems
Skin Disease
Stomach Problems
Stroke
Sulfa Allergy
Swollen Ankles
Thyroid
Tumors, cancer
Ulcers
VD (syphilis/gonorrhea)
Vomiting, Nausea
Weight Loss/fever

All Patients:
Yes No Do you have or have you had any other diseases or medical conditions NOT listed on this form?
If yes explain._____
Yes No Do you have any allergies? If yes, list each one _____

Are you taking/using?:
Yes No Recreational drugs? If yes, please list: _____
Yes No Drugs, Medications, over-the-counter medicines (including Aspirin), natural remedies?
If yes, please list:_____
Yes No Bisphosphonates (medications to increase bone density) such as: Fosamax?_____
Yes No Tobacco in any form? If yes, which form? _____
Yes No Alcohol? If yes, how often? _____

Women Only:
Yes No Are you or could you be pregnant or nursing?
Yes No Using birth control pills/ patch/ shot?

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

Patient/Parent signature: _____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____