

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

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: _____