HEALTH HISTORY

Patient Name: ____________________ Employer and Ins. Info ____________________
Address:____________________ Birth Date: ____________________
Phone: ____________________Cell phone:____________________E-Mail:____________________
Person to contact in case of an emergency:____________________SSN:____________________

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

Yes No Is your general health good?
Yes No Has there been a change in your health within the last year?
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? For what?____________________
Date of last medical exam? ____________________ Date of last dental exam ____________________
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?

II. 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 Sinus problems?
Yes No Difficulty swallowing?
Yes No Diarrhea, constipation, blood in stools?
Yes No Frequent vomiting, nausea?
Yes No Difficulty urinating, blood in urine?
Yes No Dizziness?
Yes No Ringing in ears?
Yes No Headaches?
Yes No Fainting spells?
Yes No Blurred vision?
Yes No Seizures?
Yes No Excessive thirst?
Yes No Frequent urination?
Yes No Dry mouth?
Yes No Jaundice?
Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

Yes No Heart disease?
Yes No Heart attack, heart defects?
Yes No Heart murmurs?
Yes No Rheumatic fever?
Yes No Stroke, hardening of arteries?
Yes No High blood pressure?
Yes No Asthma, TB, emphysema, other lung diseases?
Yes No Hepatitis, other liver disease?
Yes No Stomach problems, ulcers?
Yes No Allergies to: drugs, foods, medications, latex?
Please List: ____________________
Yes No Dementia / Alheizmers?
Yes No Psychiatric care?
Yes No Radiation treatments?
Yes No Chemotherapy?
Yes No Pacemaker?
Yes No Artificial joint?
Yes No HIV / AIDS?
Yes No Tumors, cancer?
Yes No Arthritis, rheumatism?
Yes No Eye diseases?
Yes No Diabetes?
Yes No Anemia?
Yes No STD (chlamydia, herpes)?
Yes No Family history of diabetes, heart problems, tumors?
Yes No Kidney, bladder disease?
Yes No Thyroid, adrenal disease?
Yes No Skin diseases?
Yes No Hospitalization?
Yes No Blood transfusions?
Yes No Surgeries?
Yes No Prosthetic heart valve?
Yes No Contact lenses?

IV. ARE YOU TAKING:

Yes No Recreational drugs?
Yes No History of chemical dependency?
If yes, how long in recovery?____________________
Yes No Drugs, medications, over-the-counter medicines (including aspirin), natural remedies/herbs?
Yes No Fosamax, Boniva or medications containing bisphosphonates?
Yes No Tobacco in any form?
Yes No Alcohol?

Please list: ____________________
____
____

V. WOMEN ONLY:

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

VI. 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: ____________________

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.

Patient's signature: ____________________ Date: ____________________

Doctor comments: ____________________
____
____
____________________ Signature ____________________Date____________________