

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

## DO YOU HAVE OR HAVE YOU HAD?

Yes / No Heart disease?	Yes / No AIDS/HIV	Yes / No Diabetes?
Yes / No Heart attack, heart defects?	Yes / No Tumors, cancer?	Yes / No Heart murmurs?
Yes / No Arthritis, rheumatism?	Yes / No Eye diseases?	Yes / No Skin diseases?
Yes / No Rheumatic fever?	Yes / No Anemia?	Yes / No Venereal disease
Yes / No Stroke, hardening of arteries?	Yes / No Kidney, bladder disease?	Yes / No Herpes?
Yes / No Psychiatric care	Yes / No Hospitalization	Yes / No Chemotherapy
Yes / No Radiation treatments	Yes / No Blood transfusions	Yes / No Contact lenses
Yes / No Artificial joint	Yes / No Pacemaker/Prosth. heart valve	Yes / No Surgeries
Yes / No Thyroid, adrenal disease?	Yes / No High blood pressure?	Yes / No Stomach problems, ulcers?
Yes / No Asthma, TB, emphysema, other lung diseases?	Yes / No Hepatitis, other liver disease?	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 Latex	Yes / No Demerol	Yes / No Erythromycin
Yes / No Darvon	Yes / No Local Anesthetic	Yes / No Penicillin	Yes / No Nitrous Oxide
Yes / No Codeine	Yes / No Valium	Yes / No Sulfa	Yes / No Metal (Please specify below)
Yes / No Percodan	Yes / No Vicodin	Yes / No Tetracycline	

Others: \_\_\_\_\_

## ARE YOU TAKING?

Yes / No Recreational drugs?	Yes / No Tobacco in any form?	Yes / No Alcohol?	Yes / No Bisphosphonate?
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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 (guardian if patient is a minor) \_\_\_\_\_ 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.*

Signature (guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_ See Clinical Notes \_\_\_\_\_  
Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_