HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Soc. Sec. No.: xxx-xx-_____
Birth Date: _____

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

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Name of Primary Physician _____ #_____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 having dental pain now? Where? _____

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Shortness of breath?
9. Yes No Recent weight loss?
10. Yes No Persistent cough, coughing up blood?
11. Yes No Bleeding problems, bruising easily?
12. Yes No Frequent vomiting, nausea?
13. Yes No Joint pain, stiffness?
14. Yes No Seizures?
15. Yes No Ringing in ears?
16. Yes No Headaches?
17. Yes No Fainting spells?
18. Yes No Dry mouth?
19. Yes No Difficulty swallowing
20. Yes No Sinus problems?

III. DO YOU HAVE OR HAVE YOU HAD:

21. Yes No Heart disease?
22. Yes No Heart attack, heart defects?
23. Yes No Heart murmurs?
24. Yes No Rheumatic fever?
25. Yes No Stroke?
26. Yes No High blood pressure?
27. Yes No Asthma, TB, emphysema, other lung diseases?
28. Yes No Hepatitis, other liver disease?
29. Yes No Stomach problems, ulcers?
30. Yes No Allergies to: drugs, foods, medications, latex? (Circle)
31. Yes No Diabetes?
32. Yes No AIDS, HIV
33. Yes No Tumors, cancer?
34. Yes No Arthritis, rheumatism?
35. Yes No Eye diseases?
36. Yes No Skin diseases?
37. Yes No Anemia?
38. Yes No STD?
39. Yes No Herpes?
40. Yes No Kidney, bladder disease?
41. Yes No Thyroid, adrenal disease?

IV. DO YOU HAVE OR HAVE YOU HAD:

42. Yes No Hospitalization?
43. Yes No Radiation treatments?
44. Yes No Chemotherapy?
45. Yes No Prosthetic heart valve?
46. Yes No Surgeries?
47. Yes No Psychiatric care?
48. Yes No Blood transfusions?
49. Yes No Artificial joint?
50. Yes No Pacemaker?

If YES to surgeries, please explain: _____
_____
_____

V. ARE YOU TAKING:

51. Yes No Recreational drugs?
53. Yes No Tobacco in any form?
54. Yes No Alcohol?
52. Yes No Drugs, medications, over-the-counter medicines (Including Aspirin), natural remedies?
Please list current medications: _____
_____

VI. ALL PATIENTS:

55. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____
_____

VII. WOMEN ONLY: 56. Yes No Are you or could you be pregnant or nursing? 57. Yes No Taking birth control pills?

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: _____ Provider: _____Date: _____

RECALL REVIEW:

1. Patient's signature: _____ Date: _____ Provider: _____Date: _____
2. Patient's signature: _____ Date: _____ Provider: _____Date: _____
3. Patient's signature: _____ Date: _____ Provider: _____Date: _____

OFFICE USE ONLY - Blood pressure**: _____** Pulse**: _____** Temp**: _____**