HEALTH HISTORY

Patient Name: _____Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER:

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? _____
5. Date of last medical exam? _____
   Physician's Contact Information:_____
6. Date of last Dental exam? _____
7. Yes No Have you had problems with prior dental treatment? _____
8. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes	No	Chest pain (angina)?	18. Yes	No	Dizziness?
8. Yes	No	Swollen ankles?	19. Yes	No	Ringing in ears?
9. Yes	No	Shortness of breath?	20. Yes	No	Headaches?
10. Yes	No	Recent weight loss, fever, night sweats?	21. Yes	No	Fainting spells?
11. Yes	No	Persistent cough, coughing up blood?	22. Yes	No	Blurred vision?
12. Yes	No	Bleeding problems, bruising easily?	23. Yes	No	Seizures?
13. Yes	No	Sinus problems?	24. Yes	No	Excessive thirst?
14. Yes	No	Difficulty swallowing?	25. Yes	No	Frequent urination?
15. Yes	No	Diarrhea, constipation, blood in stools?	26. Yes	No	Dry mouth?
16. Yes	No	Frequent vomiting, nausea?	27. Yes	No	Jaundice?
17. Yes	No	Difficulty urinating, blood in urine?	28. Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD: Please circle if only one.

29. Yes	No	Heart disease?	40. Yes	No	HIV?
30. Yes	No	Heart attack, heart defects?	41. Yes	No	AIDS?
31. Yes	No	Heart murmurs?	42. Yes	No	Arthritis, rheumatism?
32. Yes	No	Rheumatic fever?	43. Yes	No	Eye diseases?
33. Yes	No	Stroke, hardening of arteries?	44. Yes	No	Skin diseases?
34. Yes	No	High blood pressure?	45. Yes	No	Anemia?
35. Yes	No	Asthma, TB, emphysema, other lung diseases?	46. Yes	No	VD (syphilis or gonorrhea)?
36. Yes	No	Hepatitis, other liver disease?	47. Yes	No	Herpes?
37. Yes	No	Stomach problems, ulcers?	48. Yes	No	Kidney, bladder disease?
38. Yes	No	Allergies to: drugs, foods, medications, latex? _____	49. Yes	No	Thyroid, adrenal disease?
			50. Yes	No	Diabetes?
39. Yes	No	Family history of diabetes, heart problems, tumors? _____	51. Yes	No	Tumors, cancer?

IV. DO YOU HAVE OR HAVE YOU HAD:

52. Yes	No	Psychiatric care?	57. Yes	No	Hospitalization?
53. Yes	No	Radiation treatments?	58. Yes	No	Blood transfusions?
54. Yes	No	Chemotherapy?	59. Yes	No	Surgeries?
55. Yes	No	Prosthetic heart valve?	60. Yes	No	Pacemaker?
56. Yes	No	Artificial joint?	61. Yes	No	Contact lenses?

V. ARE YOU TAKING:

62. Yes No Tobacco in any form?
63. Yes No Alcohol?
64. Yes No Recreational drugs?
65. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? Please list: _____
_____
_____

VI. WOMEN ONLY:

66. Yes No Are you or could you be pregnant or nursing?
67. Yes No Taking birth control pills?

VII. ALL PATIENTS:

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

69. Yes No **Have you ever taken a antibiotic before dental treatment or been told you need to?**

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's signature:_____Date: _____