

HEALTH HISTORY

Patient Name: _____ Soc. Sec. No. _____

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?
Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last Medical Exam: _____ Date of last Dental Appt.: _____
5. Yes No Have you had problems with prior dental treatment?
6. 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 the 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:

- | | |
|--|--|
| 29. Yes No Heart disease? | 40. Yes No AIDS or ARC? |
| 30. Yes No Heart attack, heart defects? | 41. Yes No Tumors, cancer? |
| 31. Yes No Heart murmurs? | 42. Yes No Arthritis, rheumatism? |
| 32. Yes No Rheumatic fever? | 43. Yes No Eye disease? |
| 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 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? | 49. Yes No Thyroid, adrenal disease? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | 50. Yes No Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|------------------------------------|--------------------------------|
| 51. Yes No Psychiatric care? | 56. Yes No Hospitalization? |
| 52. Yes No Radiation treatments? | 57. Yes No Blood transfusions? |
| 53. Yes No Chemotherapy? | 58. Yes No Surgeries? |
| 54. Yes No Prosthetic heart valve? | 59. Yes No Pacemaker? |
| 55. Yes No Artificial joint? | 60. Yes No Contact lenses? |

V. ARE YOU TAKING:

- | | |
|---|---------------------------------|
| 61. Yes No Recreational drugs? | 63. Yes No Tobacco in any form? |
| 62. Yes No Drugs, medicines, (incl. Aspirin)? Please list: _____ | 64. Yes No Alcohol? |

VI. WOMEN ONLY:

- | | |
|---|--|
| 65. Yes No Are you or could you be pregnant or nursing? | 66. Yes No Taking birth control pills? |
|---|--|

VII. ALL PATIENTS:

67. 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 _____

RECALL REVIEW:

1. Patient's signature _____ Date _____

2. Patient's signature _____ Date _____

3. Patient's signature _____ Date _____