HEALTH HISTORY

Patient Name: Date of Birth:

I. **CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?

   If NO, explain:

2. Yes / No Has there been a change in your health within the last year?

   If YES, explain:

3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

   If YES, explain:

4. Yes / No Are you being treated by a physician now? If YES, explain:

   Date of last medical exam?

   Reason for exam:

5. Yes / No Have you had problems with prior dental treatment?

   If YES, explain:

   Date of last dental exam: Name of last treating dentist:

6. Yes / No Are you in pain now?

   If YES, explain:

II. **HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other:

III. **HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

	Yes / No Heart disease	Yes / No AIDS/HIV
	Yes / No Psychiatric care	
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis Yes
/ No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No STD
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia

Yes / No Hardening of arteries Yes / No Emphysema or other lung disease Yes / No Liver disease Yes / No High blood pressure Yes / No Kidney or bladder disease Yes / No Eye disease
Yes / No Seizures Yes / No Stroke Yes / No Transplants
Yes / No Cosmetic surgery Yes / No Eating disorders Yes / No Tuberculosis
Other:

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin Yes / No Valium or sedatives Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics Yes / No Latex Yes / No Food
Yes / No Nitrous oxide Metal Yes / No Local anesthetic
Yes / No

Others:

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No Recreational drugs Yes / No Tobacco in any form Yes / No Antibiotics
Yes / No Over-the-counter medicines Yes / No Alcohol Yes / No Supplements
Yes / No Weight loss medications Yes / No Bisphosphonate (Fosamax) Yes / No Aspirin
Yes / No Anti-Depressants Yes / No Herbal supplements
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason:

Please list all prescription medications:

VI. **WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month?

Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. **ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain:

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:

Yes / No Have you ever taken Fen-Phen? If YES, when:

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: Date:

Physician's Name: Phone Number:

Whom would you like us to contact in case of an emergency?):

Name: **Relationship:** **Phone Number:**

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or

any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS