HEALTH HISTORY

Name:

I. CIRCLE APPROPRIATE ANSWER:

Is your general health good?	Yes No
Has there been a change in your health within the last year?	Yes No
Have you been hospitalized or had a serious illness in the last three years?	Yes No
If YES, why?	
Are you being treated by a physician now?	Yes No
For what?	
Date of last medical exam:	
Date of last dental exam:	
Have you had problems with prior dental treatment?	Yes No
Are you in pain now?	Yes No

II. HAVE YOU EXPERIENCED:

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

III. DO YOU HAVE OR HAVE YOU HAD:

Heart disease?	Yes No	HIV / AIDS?	Yes No
Heart attack / heart defects?	Yes No	Tumors, cancer?	Yes No
Heart murmurs?	Yes No	Arthritis or rheumatism?	Yes No
Rheumatic fever	Yes No	Eye diseases?	Yes No
Stroke, hardening of arteries?	Yes No	Skin diseases?	Yes No
High blood pressure?	Yes No	Anemia?	Yes No
Asthma, TB, emphysema, lung problems?	Yes No	VD (syphilis or gonorrhea)?	Yes No
Hepatitis, liver disease?	Yes No	Herpes?	Yes No
Stomach problems, ulcers?	Yes No	Kidney, bladder disease?	Yes No
Family history of diabetes, heart problems?	Yes No	Diabetes	Yes No
Allergies to drugs, foods, medications, latex?	Yes No	Thyroid, adrenal disease?	Yes No

IV. DO YOU HAVE OR HAVE YOU HAD:

Psychiatric care?	Yes No	Hospitalization?	Yes No
Radiation treatments?	Yes No	Blood transfusions?	Yes No
Chemotherapy?	Yes No	Surgeries?	Yes No
Prosthetic heart valve	Yes No	Pacemakers?	Yes No
Artificial joint?	Yes No	Contact lenses?	Yes No

V. ARE YOU TAKING:

Recreational drugs?	Yes No	Tobacco in any form?	Yes No
Drugs, medications, over-the-counter		Alcohol?	Yes No
medications, natural supplements?	Yes No	Birth control pills?	Yes No

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 Signature (or authorized guardian):

If authorized guardian, relationship: Date:

HEALTH HISTORY

VI. ADDITIONAL INFORMATION:

Emergency Contact
Name: Relationship:

Phone:

Do you have any other diseases or medical problems NOT listed on this form?

Please provide a list of all medications and/or drugs you are currently taking:

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 signature (or authorized guardian):

If authorized guardian, relationship: Date: