Health History

Patient Name_____

Circle the appropriate answer:

Yes No 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 3 years?
If Yes, why?_____
Yes No Are you being treated by a physician now? For what?_____
Date of last medical exam_____Date of last dental exam_____
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?

Circle all that you have experienced:

Shortness of breath
Asthma
Tuberculosis
Emphysema
Lung disease
Persistent cough, coughing up blood
Bleeding problems, bruising easily
Sinus problems
Diarrhea, constipation, blood in stool
Frequent vomiting or nausea
Difficulty urinating, blood in urine
Frequent urination
Dizziness
Ringing in ears
Headaches
Fainting spells
Blurred vision
Seizures
Stomach problems, ulcers
Diabetes
Heart disease

Heart attack
Prosthetic heart valve
Pacemaker
Heart murmur, defect
Stroke
Hardening of arteries
High blood pressure
Chest pain
Swollen ankles
Anemia
Sickle Cell Anemia
Blood transfusion
Hemophilia
Rheumatic fever
Hepatitis A, B, C, D
Other liver disease
Jaundice
Difficulty swallowing
Food allergies
Latex allergy
Drug, medication allergies
Skin diseases

Tumors, cancer
Chemotherapy
Radiation treatments
Artificial joint
Jaw joint pain
Joint pain, stiffness
Arthritis, rheumatism
HIV/AIDS/ARC
Eye diseases
VD (syphilis or gonorrhea)
Cold sores/ herpes
Kidney, bladder disease
Thyroid, adrenal disease
Weight loss, fever, night sweats
Dry mouth
Excessive thirst
Family history of diabetes, heart problems, tumors
Psychiatric care
Drug or alcohol addiction
Motor vehicle accident
Other trauma

All patients:

Yes No Do you have or have you had any other diseases or medical conditions NOT listed on this form?
If yes, please explain:_____
Yes No Do you have any allergies? If yes, please list each one:_____
_____

Are you taking/using:

Yes No Recreational drugs? If yes, please list:_____
Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
Please list:_____
Yes No Tobacco in any form? If yes, which form?____w_____
Yes No Alcohol? If yes, how often? _____

Women only:

Yes No Are you or could you be pregnant or nursing?
Yes No Using birth control pills/patch/shot?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's or guardian's signature_____Date_____