Health History

Patient Name ____________________ Birthdate ______________ Social Security # ____-___-____

CIRCLE APPROPRIATE ANSWER (ask for help if you do not understand any questions)

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year? Explain ____________________
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? ____________________
5. YES NO Have you had problems with prior dental treatment? ____________________

Date of last Medical Exam ______________ Date of last dental appt. ______________

6. YES NO Are you in pain now?

HAVE YOU EXPERIENCED:

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

DO YOU HAVE OR HAVE HAD:

29. YES NO Heart disease?
30. YES NO Heart Attack, heart defects?
31. YES NO Heart murmurs?
32. YES NO Rheumatic fever?
33. YES NO Stroke, hardening of arteries?
34. YES NO High blood pressure?
35. YES NO TB, emphysema, other lung disease?
36. YES NO Hepatitis, other liver disease?
37. YES NO Stomach problems, ulcers, gastric reflux?
38. YES NO Allergies to drugs, foods, medication?
39. YES NO Family history: diabetes/heart problems/tumors?
40. YES NO HIV, AIDS or ARC?
41. YES NO Tumors or cancers?
42. YES NO Arthritis, rheumatism?
43. YES NO Eye disease, cataracts, glaucoma?
44. YES NO Anemia?
45. YES NO Sexually Transmitted Diseases?
46. YES NO Herpes?
47. YES NO Kidney/bladder disease?
48. YES NO Thyroid or adrenal disease?
49. YES NO Diabetes?
50. YES NO Skin disease, eczema, acne, rosacea?

DO YOU HAVE OR HAVE YOU HAD:

51. YES NO Psychiatric care?
52. YES NO Radiation Treatments?
53. YES NO Chemotherapy?
54. YES NO Prosthetic heart valve?
55. YES NO Artificial joint?
56. YES NO Hospitalization?
57. YES NO Blood transfusion?
58. YES NO Surgeries?
59. YES NO Pacemaker?
60. YES NO Contact lenses?

ARE YOU TAKING:

61. YES NO Recreational drugs?
62. YES NO Drugs, medicines, (incl. Aspirin, cannibis)? Please list: ____________________
63. YES NO Tobacco in any form?
64. YES NO Alcohol?

WOMEN ONLY:

65. YES NO Are you or could you be pregnant or nursing?
66. YES NO Taking birth control pills?

ALL PATIENTS:

67. YES NO Do you 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 Signature ____________________ Date ______________

RECALL REVIEW:

1. Patient Signature ____________________ Any changes? ☐YES ☐ NO ______ Staff initial Date ______________
2. Patient Signature ____________________ Any changes? ☐YES ☐ NO ______ Staff initial Date ______________
3. Patient Signature ____________________ Any changes? ☐YES ☐ NO ______ Staff initial Date ______________
4. Patient Signature ____________________ Any changes? ☐YES ☐ NO ______ Staff initial Date ______________