

# Health History

Patient Name: \_\_\_\_\_

**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?  
If YES, why? \_\_\_\_\_
4. Yes No Are you being treated by a physician now? For what? \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Date of last dental exam \_\_\_\_\_
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 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?                       |
| 30. Yes No Heart attacks, 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 disease?               |
| 34. Yes No High blood pressure?                                | 45. Yes No Anemia?                     |
| 35. Yes No Asthma, TB, emphysema, other lung disease?          | 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, latex?     | 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 treatment?    | 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, medications, over-the-counter medicines<br>(including Aspirin), natural remedies? | 64. Yes No Alcohol?             |

Please list: \_\_\_\_\_

**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: \_\_\_\_\_

<b>Office Use Only</b>			
<b>Dentist Review:</b>	<b>Date:</b>	<b>Dentist Review:</b>	<b>Date:</b>
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