**HEALTH HISTORY**

**Patient Name:** _____ **Birth Date:** _____

**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 experiencing any pain now? |

**II HAVE YOU EVER 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 or 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? | 44 | *YES* | *NO* | HIV+ ? |
| 30 | *YES* | *NO* | Heart Attack, Heart Defects? | 45 | *YES* | *NO* | Tumors, Cancer? |
| 31 | *YES* | *NO* | Heart Murmurs? | 46 | *YES* | *NO* | Arthritis, Rheumatism? |
| 32 | *YES* | *NO* | Rheumatic Fever? | 47 | *YES* | *NO* | Eye Disease, Skin Disease? |
| 33 | *YES* | *NO* | Stroke, hardening of arteries? | 48 | *YES* | *NO* | Anemia? |
| 34 | *YES* | *NO* | High Blood Pressure? | 49 | *YES* | *NO* | VD (syphilis/gonorrhea)? |
| 35 | *YES* | *NO* | Asthma, TB, Emphysema, other Lung Disease? | 50 | *YES* | *NO* | Herpes? |
| 36 | *YES* | *NO* | Hepatitis, other Liver Disease? | 51 | *YES* | *NO* | Kidney or Bladder Disease? |
| 37 | *YES* | *NO* | Stomach problems, Ulcers? | 52 | *YES* | *NO* | Thyroid or Adrenal Disease? |
| 38 | *YES* | *NO* | Family History of Diabetes, Heart Problem, Tumors? | 53 | *YES* | *NO* | Diabetes? |
| 39 | *YES* | *NO* | Psychiatric Care? | 54 | *YES* | *NO* | Hospitalization |
| 40 | *YES* | *NO* | Radiation Treatments? | 55 | *YES* | *NO* | Blood Transfusions? |
| 41 | *YES* | *NO* | Chemotherapy? | 56 | *YES* | *NO* | Surgeries? |
| 42 | *YES* | *NO* | Prosthetic Heart Valve? | 57 | *YES* | *NO* | Pacemaker? |
| 43 | *YES* | *NO* | Artificial Joint? | 58 | *YES* | *NO* | Contact Lenses? |

**IV ALLERGIES:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 60 | *YES* | *NO* | Sulfa or Sulfur? | 62 | *YES* | *NO* | Latex? |
| 61 | *YES* | *NO* | Penicillin | 63 | *YES* | *NO* | Foods or Chemicals? |
| 64 | *Yes* | *No* | Other Antibiotics? Please List _____ | | | | |

**V ARE YOU TAKING:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 64 | *YES* | *NO* | Bisphosphonate Drugs such as Fosamax? | 67 | *YES* | *NO* | Tobacco in any form? |
| 65 | *YES* | *NO* | Recreational Drugs? | 68 | *YES* | *NO* | Alcohol? |
| 66 | *YES* | *NO* | Drugs, Medications, Over-the-Counter Medications | 69 | *YES* | *NO* | Antibiotics? |
| | | | (including Aspirin), or Natural remedies? | 70 | *YES* | *NO* | Pain Medications? |

66 Please List: _____

**VII ALL PATIENTS:**

| | | | |
|---|---|---|---|
| 71 | *YES* | *NO* | Do you have or have had any other diseases or medical problems NOT listed on this form? |

If so, please explain: _____

| | | | |
|---|---|---|---|
| 72 | *YES* | *NO* | Do you require premedication with an Antibiotic prior to dental treatment? |

**VI WOMEN ONLY:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 73 | *YES* | *NO* | Are you or could you be pregnant or nursing? | 74 | *YES* | *NO* | Taking any birth control pills? |

**Patient Signature:** _____ **Date:** _____