

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?

**III DO YOU HAVE OR HAVE YOU HAD:**

- |  |                                       |
|--|---------------------------------------|
| 7 YES NO Heart Disease?                                      | 22 YES NO HIV+ ?                      |
| 8 YES NO Heart Attack, Heart Defects?                        | 23 YES NO Tumors, Cancer?             |
| 9 YES NO Heart Murmurs?                                      | 24 YES NO Arthritis, Rheumatism?      |
| 10 YES NO Rheumatic Fever?                                   | 25 YES NO Eye Disease, Skin Disease?  |
| 11 YES NO Stroke, hardening of arteries?                     | 26 YES NO Anemia?                     |
| 12 YES NO High Blood Pressure?                               | 27 YES NO VD (syphilis/gonorrhea)?    |
| 13 YES NO Asthma, TB, Emphysema, other Lung Disease?         | 28 YES NO Herpes?                     |
| 14 YES NO Hepatitis, other Liver Disease?                    | 29 YES NO Kidney or Bladder Disease?  |
| 15 YES NO Stomach problems, Ulcers?                          | 30 YES NO Thyroid or Adrenal Disease? |
| 16 YES NO Family History of Diabetes, Heart Problem, Tumors? | 31 YES NO Diabetes?                   |
| 17 YES NO Psychiatric Care?                                  | 32 YES NO Hospitalization             |
| 18 YES NO Radiation Treatments/Chemotherapy?                 | 33 YES NO Blood Transfusions?         |
| 19 YES NO Seizures?  | 34 YES NO Surgeries?                  |
| 20 YES NO Prosthetic Heart Valve?                            | 35 YES NO Pacemaker?                  |
| 21 YES NO Artificial Joint?                                  | 36 YES NO Contact Lenses?             |

**IV ALLERGIES:**

- |   |                               |
|---|-------------------------------|
| 37 YES NO Sulfa or Sulfur?                                | 40 YES NO Latex?              |
| 38 YES NO Penicillin                                      | 41 YES NO Foods or Chemicals? |
| 39 Yes No Other Meds, Foods, Chemicals? Please List _____ |                               |

**V ARE YOU TAKING:**

- |   |                                |
|---|--------------------------------|
| 42 YES NO Bisphosphonate Drugs such as Fosamax?   | 45 YES NO Tobacco in any form? |
| 43 YES NO Recreational Drugs?   | 46 YES NO Alcohol?             |
| 44 YES NO Drugs, Medications, Over-the-Counter Medications<br>(including Aspirin), or Natural remedies? | 47 YES NO Antibiotics?         |
|   | 48 YES NO Pain Medications?    |

49 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 due to Artificial Jointt or MVP?

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