



CONFIDENTIAL HEALTH HISTORY

Patient Name: _____

Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER:

1. Yes / No Is your general health good?
 If NO, explain: _____

2. Yes / No Has there been a change in your health within the last year?
 If YES, explain: _____

3. Yes / No Have you had a serious illness in the last three years?
 If YES, explain: _____

4. Yes / No Are you being treated by a physician now?
 If YES, explain: _____
 Date of last medical exam? _____
 Reason for exam: _____

5. Yes / No Have you had problems with prior dental treatment?
 If YES, explain: _____
 Date of last dental exam? _____
 Name of last treating dentist: _____

6. Yes / No Are you in pain now?
 If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|--|--|---------------------------------------|
| Yes / No Heart disease | Yes / No AIDS/HIV | Yes / No Psychiatric care |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexually transmitted disease |
| Yes / No Heart murmurs | Yes / No Radiation | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| Yes / No Cosmetic surgery | Yes / No Eating disorders | Yes / No Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|--|------------------------------------|-------------------------------------|
| Yes / No Aspirin | Yes / No Valium or other sedatives | Yes / No Codeine or other narcotics |
| Yes / No Penicillin or other antibiotics | Yes / No Latex | Yes / No Food |
| Yes / No Nitrous oxide | Yes / No Local anesthetic | Yes / No Metal |
- Other: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

- | | | |
|-------------------------------------|----------------------------------|----------------------|
| Yes / No Recreational drugs | Yes / No Tobacco in any form | Yes / No Antibiotics |
| Yes / No Over-the-counter medicines | Yes / No Alcohol | Yes / No Supplements |
| Yes / No Weight loss medications | Yes / No Biphosphonate (Fosamax) | Yes / No Aspirin |
| Yes / No Anti-Depressants | Yes / No Herbal Supplements | |
- Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If Yes, what month? _____
- Yes / No Are you nursing?
- Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If Yes, please explain: _____
- Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
- Yes / No Have you ever taken fen-Phen? If YES, when: _____
- Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature

Date

Physician's Name

Date

Whom would you like us to contact in case of an emergency?

Name

Relationship

Phone Number

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature (Parent or Guardian)

Date

Dentist's Signature

Date