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*	AIDS?
	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 (including Aspirin), or Natural remedies?	69	*YES*	*NO*	Antibiotics?
				70	*YES*	*NO*	Pain Medications?

Please List: ______________________________

VII ALL PATIENTS:

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

If so, please explain: ______________________________

VI WOMEN ONLY:

71	*YES*	*NO*	Are you or could you be pregnant or nursing?	72	*YES*	*NO*	Taking any birth control pills?

medication.

Patient Signature: ______________________________ Date: ______________