Health History

Name_____ Birthdate_____
Height_____ Weight_____

DENTAL

1. Are you having any discomfort at this time?..... Yes_____ No_____
2. Have you ever had any serious trouble associated with dental treatment?..... Yes_____ No_____
If yes, please
explain_____
3. Does dental treatment make you nervous?..... Extremely ____ Moderately _____ Slightly _____ No _____
4. Date of last dental visit_____
5. Do you have bleeding gums, unpleasant taste/bad breath?..... Yes_____ No_____
6. Is there anything you would like to change about your teeth?..... Yes_____ No_____
If yes, please
explain_____
7. Do you have well or city water?..... Well_____ City____
8. Are you now or have you been under the care of any dental specialist?..... Yes_____ No_____

MEDICAL

9. Have you had any serious illness or medical condition in the last 5 years?..... Yes____ No_____
If yes, please
explain_____
10. Any major surgeries?..... Yes____ No____
If Yes, Please
List_____ _____
11. Physicians Name _____ Phone Number_____
Address_____
Do you have or have you ever had any of the following:

CARDIOVASCULAR/BLOOD DISORDERS

12. Frequent headaches in the morning?…… Yes____ No____ Don't Know_____
13. Hypertension (high blood pressure)?..... Yes____ No____ Don't Know_____
14. Heart attack, murmur, damaged heart valves, angina?..... Yes____ No____ Don't Know_____
15. Heart surgery, pacemaker, irregular heart rate?..... Yes____ No____ Don't Know_____
16. Stroke?.....Yes____ No____ Don't Know_____
17. Chest Pain/shortness of breath, dizziness/fainting spells?..... Yes____ No____ Don't Know_____
18. Blood disorders such as hemophilia or anemia?..... Yes____ No____ Don't Know_____
19. Frequent nosebleeds, increased bruising or bleeding?..... Yes____ No____ Don't Know_____
20. Have you had a blood transfusion?..... Yes____ No____ Don't Know_____
21. Seizures?..... Yes____ No____ Don't Know_____

ALLERGIES AND IMMUNE SYSTEM

22. Asthma, tuberculosis?..... Yes____ No____ Don't Know_____
23. Have you been told you have AIDS or a positive HIV test?..... Yes____ No____ Don't Know____
24. Have you ever had an adverse reaction to any drugs?..... Yes____ No____ Don't Know_____
If yes, describe reaction_____
25. Do you have environmental allergies?..... Yes____ No____ Don't Know____
26. Are you allergic or have you ever experienced any reaction to the following:
Local Anesthetics (e.g. Novocain)…… Yes____ No____ Don't Know_____
Penicillin/other antibiotics…… Yes____ No____ Don't Know____
Sulfa drugs…… Yes____ No____ Don't Know____
Pain killers…… Yes____ No____ Don't Know____
Aspirin…… Yes____ No____ Don't Know_____
Iodine…… Yes____ No____ Don't Know_____
Latex…… Yes____ No____ Don't Know_____

Other medications…… Yes____ No____ Don't Know _____
If yes, what
medication_____

MEDICATION

27. Are you taking any medications now?.....Yes____ No____ Don't Know_____
28. If yes, please list the prescription drugs and non-prescription drugs

_____
_____
_____
_____

Today's Date _____

HABITS

29. Do you use tobacco in any form? ……. Yes_____ No_____
If yes, how much and what form?_____
30. How many alcoholic drinks do you consume in a day?_____ Week_____ Month_____

WOMEN

31. Are you pregnant?..... Yes____ No____ Don't Know____
32. Are you taking birth control?..... Yes____ No____ Don't Know____
33. Are you taking hormone replacement therapy?..... Yes____ No____ Don't Know____

GASTROINTESTINAL

34. Ulcers, stomach or intestinal problems?..... Yes____ No____ Don't Know____
35. Hepatitis (jaundice) or liver disease?..... Yes____ No____ Don't Know____

ENDOCRINE

36. Diabetes (high blood sugar)?…… Yes____ No____ Don't Know____
37. Thyroid condition?..... Yes____ No____ Don't Know____

GENERAL

38. Are you in good health?.....Yes____ No____ Don't Know____
39. Arthritis (painful, swollen joints)?…… Yes____ No___ Don't Know____
40. Have you ever had an artificial joint replacement?.....Yes____ No____ Don't Know____
41. Any personal history of cancer, chemotherapy, radiation.....Yes____ No____ Don't Know____
If yes, please explain_____
42. Venereal Disease (syphilis, gonorrhea, herpes, or other)?…… Yes____ No____ Don't Know____
43. Respiratory problems, emphysema, bronchitis?..... Yes____ No____ Don't Know____
44. Have you ever required antibiotics before dental treatment?.....Yes____ No____ Don't Know____
45. Any other conditions we should be aware of?.....Yes____ No____ Don't Know____
If Yes, Please explain _____
_____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or change in my medications, I will inform the dentist at the next appointment.

SIGNATURE_____ Date_____
(Adult if patient is a minor)
DR. SIGNATURE_____ Date_____
EXAMINER'S COMMENTS:

_____
_____

Date	Update