Health History

Patient Name:______________________ **Birth Date:**________________________

Circle Appropriate Answer:

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/had a serious illness in the last three years?
   If YES, why ____
4. Yes No Are you being treated by a physician now?
   If yes for what?__________________________________
   Date of last exam?____________ Date of last Dental exam?__________
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

Have You Experienced:

7. Yes No Chest pain(angina)?
8. Yes No Swollen Ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss,fever,night sweats
11. Yes No Persistent cough,coughing up blood?
12. Yes No Bleeding problems,bruising easily?
13. Yes No Sinus Problems?
14. Yes No Difficulty Swallowing?
15. Yes No Diarrhea,constipation,blood in stool?
16. Yes No Frequent vomiting,nausea?
17. Yes No Difficulty urinating,blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain,stiffness?

Do You Have Or Have You Had:

29. Yes No Heart Disease?
30. Yes No Heart attack,heart defects?
31. Yes No Heart Mumurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke,hardening of arteries?
34. Yes No High bloosd pressure?
35. Yes No Asthma,TB,emphysema/other
36. Yes No Hepatitis/other liver diseases?
37. Yes No Stomach problems/ulcers?
38. Yes No Allergies?____________
39. Yes No Family history of diabetes, Heart problems,Tumors?
40. Yes No AIDS?
41. Yes No Tumors,Cancer?
42. Yes No Arthritis,rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin Diseases?
45. Yes No Anemia?
46. Yes No VD(syphilis/gonorrhea?
47. Yes No Herpes?
48. Yes No Kidney,bladder disease?
49. Yes No Thyroid,adrenal diseas?
50. Yes No Diabetes?

Do You Have Or Had:

51. Yes No Psychiatric care?
52. Yes No Radiation treatment?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusion?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

Are You Takeing:

61. Yes No Recreational drugs?
62. Yes No Drugs,medications?
63. Yes No Tobacco?
64. Yes No Alcohol?

65.**Do you have or had any other diseases or medical problems NOT listed in this form?**
If so,please explain:

____

Women Only:

66. Yes No Could you/are you pregnant or nursing?
67. Yes No Takeing birth control pills?

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.

Patient's signature:____________________________ **Date:** ______________