# 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 in pain now?

**II. HAVE YOU 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, 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? | 40. | Yes | NO | AIDS |
| 30. | Yes | No | Heart attack, heart defects? | 41. | Yes | NO | Tumors, cancer? |
| 31. | Yes | No | Heart murmurs? | 42. | Yes | No | Arthritis, rheumatism? |
| 32. | Yes | No | Rheumatic fever? | 43. | Yes | No | Eye diseases? |
| 33. | Yes | No | Stroke, hardening of arteries? | 44. | Yes | No | Skin diseases? |
| 34. | Yes | No | High blood pressure? | 45. | Yes | No | Anemia? |
| 35. | Yes | No | Asthma, TB, emphysema, other lung diseases? | 46. | Yes | No | VD (syphilis or gonorrhea)? |
| 36. | Yes | No | Hepatitis, other liver disease? | 47. | Yes | No | Herpes? |
| 37. | Yes | No | Stomach problems, ulcers? | 48. | Yes | No | Kidney, bladder disease? |
| 38. | Yes | No | Allergies to: drugs, foods, medications, latex? | 49. | Yes | No | Thyroid, adrenal disease? |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors? | 50. | Yes | No | Diabetes? |

**IV. DO YOU HAVE OR HAVE YOU HAD:**

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

**V. ARE YOU TAKING :**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 61. | Yes | No | Recreational drugs? | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? | 64. | Yes | No | Alcohol? |

Please list: _____

_____

**VI. WOMEN ONLY:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 65. | Yes | No | Are you or could you be pregnant or nursing? | 66. | Yes | No | Taking birth control pills? |

**VII. ALL PATIENTS:**

67. Yes No **Do you or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:**

_____

_____

*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: _____ Doctor's Review Signature _____ Date _____