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Health History

Section 1. Patient Information

First Name | Last Name | Patient ID | Date of Birth *(month/day/year)* | Sex

______________________|_______________________|______________________|_____________________________|_______________

Section 2. Circle appropriate answer

	YES	NO	Questions (*leave blank if you do not understand question*)
1.	◯	◯	Is your general health good?
2.	◯	◯	Has there been a change in your health within the last year?
3.	◯	◯	Have you been hospitalized or had a serious illness in the last three years? If yes, why?____
4.	◯	◯	Are you being treated by a physician now? For what?__________________________ Date of last medical exam_____________ Date of last dental exam_______________
5.	◯	◯	Have you had problems with prior dental treatment?
6.	◯	◯	Are you in pain now?

Section 3. Have you experienced

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

Section 4. Do you have or have you had

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

Section 5. Have you experienced

	YES	NO	Questions		YES	NO	Questions
51.	◯	◯	Psychiatric care	56	◯	◯	Hospitalization
52.	◯	◯	Radiation treatments	57	◯	◯	Blood transfusions
53.	◯	◯	Chemotherapy	58	◯	◯	Surgeries
54.	◯	◯	Prosthetic heart valve	59	◯	◯	Pacemaker
55.	◯	◯	Artificial joint	60	◯	◯	Contact lenses

Section 6. Are you taking

	YES	NO	Questions		YES	NO	Questions
61.	◯	◯	Recreational drugs	63.	◯	◯	Tobacco in any form
62.	◯	◯	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	◯	◯	Alcohol. Please list_____________________

Section 7. Women only

	YES	NO	Questions		YES	NO	Questions
65.	◯	◯	Are you or could you be pregnant or nursing	66.	◯	◯	Taking birth control pills

Section 7. All patients

	YES	NO	Questions
67.	◯	◯	Do you have or have you had any other diseases or medical problems NOT listed on this form?

If yes, please explain below.

To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any changes in my health and/or medication.

Patient's Signature Date

(Or Legal Guardian if minor)

Recall Review:

1. Patient's Signature Date
2. Patient's Signature Date
3. Patient's Signature Date