HEALTH HISTORY

Patient Name: _____ **Soc Sec #**_____

DOB: _____

I. CIRCLE THE APPROPRIATE ANSWER (leave BLANK if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your helath within the last year?
3. Yes No Have you been hospitalized or had 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: _____

II. HAVE YOU EXPERIENCED:

5.	Yes	No	Chest Pain(angina)?	13.	Yes	No	Dizziness?
6.	Yes	No	Shortness of breath?	14.	Yes	No	Headaches?
7.	Yes	No	Persistent Cough, coughing up blood?	15.	Yes	No	Fainting spells?
8.	Yes	No	Bleeding problems, bruising easily?	16.	Yes	No	Blurred vision?
9.	Yes	No	Sinus Problems?	17.	Yes	No	Seizures?
10.	Yes	No	Difficulty swallowing?	18.	Yes	No	Excessive thirst?
11.	Yes	No	Diarrhea, constipation, blood in stools?	19.	Yes	No	Dry mouth?
12.	Yes	No	Frequent vomiting, nausea?	20.	Yes	No	Jaundice?

III. DO YOU HAVE OR HAVE YOU HAD:

21.	Yes	No	Heart Disease?	35.	Yes	No	AIDS?
22.	Yes	No	Heart Attack, heart defects?	36.	Yes	No	Tumors, cancer?
23.	Yes	No	Heart murmurs?	37.	Yes	No	Arthritis, rheumatism?
24.	Yes	No	Rheumatic fever?	38.	Yes	No	Skin diseases?
25.	Yes	No	Stroke, hardening of arteries/	39.	Yes	No	Anemia?
26.	Yes	No	High blood pressure?	40.	Yes	No	VD (syphilis/gonorrhea)?
27.	Yes	No	Asthma, TB, emphysema, other lung diseases?	41.	Yes	No	Herpes?
28.	Yes	No	Hepatitis, other liver disease?	42.	Yes	No	Thyroid, Adrenal disese?
29.	Yes	No	Stomach problems, ulcers?	43.	Yes	No	Diabetes?
30.	Yes	No	Family history of diabetes, heart problems, tumors?	44.	Yes	No	Blood transfusions?
31.	Yes	No	Radiation treatments?	45.	Yes	No	Surgeries?
32.	Yes	No	Chemotherapy?	46.	Yes	No	Pacemaker?
33.	Yes	No	Prosthetic heart valve?				
34.	Yes	No	Artificial joint?				

IV. ARE YOU ALLERGIC TO:

47.	Yes	No	Local anesthetics (i.e. novocaine)	52.	Yes	No	Sedatives?
48.	Yes	No	Penicillin or other antibiotics?	53.	Yes	No	Iodine?
49.	Yes	No	Sulfa drugs?	54.	Yes	No	Aspirin?
50.	Yes	No	Barbituaries?	55.	Yes	No	Other? _____
51.	Yes	No	Phen-Fen?				

V. ARE YOU TAKING:

56.	Yes	No	Recreational drugs?	58.	Yes	No	Tobacco in any form?
57.	Yes	No	Drugs, medications, over the counter medicines (including aspirin), natural remedies?	59.	Yes	No	Alcohol?

Please list ALL medications you are taking? _____

_____

VI. WOMEN ONLY:

60. Yes No Are you or could you be pregnant or nursing? 61. Yes No Taking birth control?

VII. ALL PATIENTS:

62. Yes No Do you have or have you had any other disease or medical problems NOT listed on this form?

If so, explain: _____

_____

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.

Guardian / Patient Signature: _____ Date: _____

Updated 3-2016