Submit by Email Print Form

HEALTH HISTORY
English

Patient Name: _____ Patient Identificationumber:_____

Date of Birth :

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?s

6. Yes No Are you in pain now?

II. 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 stools?

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?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?

30. Yes No Heart attack, heart defects?

31. Yes No Heart murmurs?

32. Yes No Rheumatic fever?

40. Yes No AIDS

41. Yes No Tumors, cancer?

42. Yes No Arthritis, rheumatism?

43. Yes No Eye diseases?

33. ○ **Yes** ○ **No** **Stroke, hardening of arteries?**

34. ○ **Yes** ○ **No** **High blood pressure?**

35. ○ **Yes** ○ **No** **Asthma, TB, emphysema, other lung diseases?**

36. ○ **Yes** ○ **No** **Hepatitis, other liver disease?**

37. ○ **Yes** ○ **No** **Stomach problems, ulcers?**

38. ○ **Yes** ○ **No** **Allergies to: drugs, foods, medications, latex?**

39. ○ **Yes** ○ **No** **Family history of diabetes, heart problems, tumors?**

44. ○ **Yes** ○ **No** **Skin diseases?**

45. ○ **Yes** ○ **No** **Anemia?**

46. ○ **Yes** ○ **No** **VD (syphilis or gonorrhea)?**

47. ○ **Yes** ○ **No** **Herpes?**

48. ○ **Yes** ○ **No** **Kidney, bladder disease?**

49. ○ **Yes** ○ **No** **Thyroid, adrenal disease?**

50. ○ **Yes** ○ **No** **Diabetes?**

IV. DO YOU HAVE OR HAVE YOU HAD:

51. ○ **Yes** ○ **No** **Psychiatric care?**

52. ○ **Yes** ○ **No** **Radiation treatments?**

53. ○ **Yes** ○ **No** **Chemotherapy?**

54. ○ **Yes** ○ **No** **Prosthetic heart valve?**

55. ○ **Yes** ○ **No** **Artificial joint?**

56. ○ **Yes** ○ **No** **Hospitalization?**

57. ○ **Yes** ○ **No** **Blood transfusions?**

58. ○ **Yes** ○ **No** **Surgeries?**

59. ○ **Yes** ○ **No** **Pacemaker?**

60. ○ **Yes** ○ **No** **Contact lenses?**

V. ARE YOU TAKING:

61. ○ **Yes** ○ **No** **Recreational drugs?**

62. ○ **Yes** ○ **No** **Drugs, medications, over-the-counter medicines natural remedies?**

63. ○ **Yes** ○ **No** **Tobacco in any form?**

64. ○ **Yes** ○ **No** **Alcohol? (including , Aspirin),**

Please list: _____

_____

VI. WOMEN ONLY:

65. ○ **Yes** ○ **No** **Are you or could you be pregnant**

66. ○ **Yes** ○ **No** **Taking birth control pills? or nursing?**

VII. ALL PATIENTS:

67. ○ **Yes** ○ **No** **Do you have 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:

RECALL REVIEW:

1. Patient's signature _____ Date:

2. Patient's signature _____ Date:

3. Patient's signature _____ Date: