



Health History

Patient Name: _____ Patient Identification Number: _____
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 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: _____ |