Patient Health History

Patient Name:_____ **Date of Birth:** _____

I. CHECK MARK APPROPRIATE ANSWER – (LEAVE BLANK IF YOU DO NOT UNDERSTAND THE QUESTION)

a) Is your general health good? ☐ Yes ☐ No ; if **No,** explain: _____

b) Has there been a change in your health within the last year? ☐ Yes ☐ No; if **Yes,** explain: _____

_____

c) Have you gone to the hospital or emergency room or had a serious illness in the las year? ☐ Yes ☐ No; If **Yes,** explain: _____

d) Are you being treated by a physician now? ☐ Yes ☐ No; If **Yes,** explain: _____

i) When was your last medical exam: _____

ii) Reason for exam: _____

e) Are you in pain now? ☐ Yes ☐ No; If **Yes,** explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK MARK EACH)

a)	Chest Pain (Angina)	☐ Yes ☐ No	o)	Headaches	☐ Yes ☐ No
b)	Fainting Spells	☐ Yes ☐ No	p)	Dizziness	☐ Yes ☐ No
c)	Recent Significant Weight Loss	☐ Yes ☐ No	q)	Blurred Vision	☐ Yes ☐ No
d)	Fever	☐ Yes ☐ No	r)	Bruise Easily	☐ Yes ☐ No
e)	Night Sweats	☐ Yes ☐ No	s)	Frequent Vomiting	☐ Yes ☐ No
f)	Persistent Cough	☐ Yes ☐ No	t)	Jaundice	☐ Yes ☐ No
g)	Coughing up Blood	☐ Yes ☐ No	u)	Dry Mouth	☐ Yes ☐ No
h)	Bleeding Problems	☐ Yes ☐ No	v)	Excessive Thirst	☐ Yes ☐ No
i)	Blood in Urine	☐ Yes ☐ No	w)	Difficulty Swallowing	☐ Yes ☐ No
j)	Blood in Stools	☐ Yes ☐ No	x)	Swollen Ankles	☐ Yes ☐ No
k)	Diarrhea or Constipation	☐ Yes ☐ No	y)	Join Pain or Stiffness	☐ Yes ☐ No
l)	Frequent Urination	☐ Yes ☐ No	z)	Shortness of Breath	☐ Yes ☐ No
m)	Difficulty Urinating	☐ Yes ☐ No	aa)	Sinus Problems	☐ Yes ☐ No
n)	Ringing in Ears	☐ Yes ☐ No	bb)	Other: _____	

III. HAVE YOU EVER HAD, OR DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CHECK MARK YES OR NO FOR EACH)

a)	Heart Disease	☐ Yes ☐ No	p)	Hospitalization	☐ Yes ☐ No
b)	Family History of Heart Disease	☐ Yes ☐ No	q)	Diabetes	☐ Yes ☐ No
c)	Heart Attack	☐ Yes ☐ No	r)	Family History of Diabetes	☐ Yes ☐ No
d)	Artificial Joint	☐ Yes ☐ No	s)	Tumors or Cancer	☐ Yes ☐ No
e)	Stomach Problems or Ulcers	☐ Yes ☐ No	t)	Chemotherapy	☐ Yes ☐ No
f)	Heart Defects	☐ Yes ☐ No	u)	Radiation	☐ Yes ☐ No
g)	Heart Murmurs	☐ Yes ☐ No	v)	Arthritis, Rheumatism	☐ Yes ☐ No
h)	Rheumatic Fever	☐ Yes ☐ No	w)	Emphysema or other Lung Disease	☐ Yes ☐ No
i)	Skin Disease	☐ Yes ☐ No	x)	Kidney or Bladder Disease	☐ Yes ☐ No
j)	Hardening of Arteries	☐ Yes ☐ No	y)	Stroke	☐ Yes ☐ No
k)	High Blood Pressure	☐ Yes ☐ No	z)	Eating Disorders	☐ Yes ☐ No
l)	Seizures	☐ Yes ☐ No	aa)	Psychiatric Care	☐ Yes ☐ No
m)	Cosmetic Surgery	☐ Yes ☐ No	bb)	Osteoporosis	☐ Yes ☐ No
n)	AIDS/HIV	☐ Yes ☐ No	cc)	Thyroid Disease	☐ Yes ☐ No
o)	Surgeries	☐ Yes ☐ No	dd)	Asthma	☐ Yes ☐ No

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ee) Hepatitis ☐ Yes ☐ No
ff) Sexual transmitted Disease ☐ Yes ☐ No
gg) Herpes ☐ Yes ☐ No
hh) Canker or Cold Sores ☐ Yes ☐ No
ii) Anemia ☐ Yes ☐ No
jj) Liver Disease ☐ Yes ☐ No
kk) Eye Disease ☐ Yes ☐ No
ll) Transplants ☐ Yes ☐ No
mm) Tuberculosis ☐ Yes ☐ No
nn) Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (PLEASE CHECK MARK YES OR NO FOR EACH)

a) Aspirin ☐ Yes ☐ No
b) Penicillin or other Antibiotics ☐ Yes ☐ No
c) Nitrous Oxide ☐ Yes ☐ No
d) Metal ☐ Yes ☐ No
e) Valium ☐ Yes ☐ No
f) Latex ☐ Yes ☐ No
g) Local Anesthetic ☐ Yes ☐ No
h) Codeine or Other Opioids ☐ Yes ☐ No
i) Food ☐ Yes ☐ No
j) Other: _____

V. ARE YOU TAKING OR HAVE TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (PLEASE CHECK MARK YES OR NO FOR EACH)

a) Recreational Drugs ☐ Yes ☐ No
b) Over-the-Counter Medications ☐ Yes ☐ No
c) Weight Loss Medications ☐ Yes ☐ No
d) Anti-Depressants ☐ Yes ☐ No
e) Tobacco in any form ☐ Yes ☐ No
f) Alcohol ☐ Yes ☐ No
g) Bisphosphonate (Fosamax) ☐ Yes ☐ No
h) Herbal Supplements ☐ Yes ☐ No
i) Antibiotics ☐ Yes ☐ No
j) Supplements ☐ Yes ☐ No
k) Aspirin ☐ Yes ☐ No
l) Opioids (e.g., Norco, Vicodin, Percocet, Percodan) ☐ Yes ☐ No If **Yes,** please explain reason: _____
m) Please list Other Medication: _____

VI. <u>WOMEN ONLY (PLEASE CHECK MARK YES OR NO FOR EACH)</u>

a) Are you of could you be pregnant? ☐ Yes ☐ No If **Yes,** what months? _____
b) Are you nursing? ☐ Yes ☐ No
c) Are you taking Birth Control Pills? ☐ Yes ☐ No

VII. ALL PATIENTS (PLEASE CHECK MARK YES OR NO FOR EACH)

a) Do you have or have you had any other disease or medical problems. NOT listed on this form. ☐ Yes ☐ No If **Yes,** please explain: _____

b) Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No If Yes, why: _____
_____

c) Have you ever taken Fen-Phen? ☐ Yes ☐ No If **Yes**, when: _____

d) Is there any issues or conditions that you would like to discuss with the dentist in private? ☐ Yes ☐ No

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically- compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's/Guardian's Signature: _____ Date: _____

Physician's Name:_____ Phone #: _____ Fax #: _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____
Signature of Patient (Parent or Guardian) Date Dentist Signature Date