



Name:	Date of Birth	Chart #
-------	---------------	---------

HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

- 1. Have you had any health problems in the past five (5) years?..... Yes No
- 2. Have you seen a physician or other health care provider in the past two (2) years?..... Yes No
- Physician's Name: _____ Phone # or City: _____
- 3. Is there any activity your doctor says you cannot do?..... Yes No
- If yes, what are they? _____
- 4. Have you been hospitalized or had a serious injury in the past five (5) years?..... Yes No
- 5. Have you ever had a bleeding problem?..... Yes No

Please answer each question, check yes or no. If in doubt, leave blank.

Heart/Blood Vessels

- rheumatic fever..... Yes No
- rheumatic heart disease..... Yes No
- heart valve damage..... Yes No
- heart murmur..... Yes No
- congenital heart defect..... Yes No
- artificial heart valve..... Yes No
- prolapsed heart valve..... Yes No
- high blood pressure..... Yes No
- heart attack (Year ____). Yes No
- TIA/stroke (Year ____). Yes No
- heart surgery (Year ____). Yes No
- vascular surger (Year ____).. Yes No
- pacemaker..... Yes No
- coronary heart failure..... Yes No
- congestive heart failure..... Yes No
- angina pectoris/chest pain..... Yes No
- irregular/rapid heart beats..... Yes No
- other heart/vessel disorder: _____

Blood

- blood clots or thrombosis..... Yes No
- anemia..... Yes No
- sickle cell disease/trait..... Yes No
- hemophilia..... Yes No
- transfusion (Year ____). Yes No
- bruise easity for no reason..... Yes No
- other blood disorder: _____

Nervous System

- epilepsy..... Yes No
- seizures..... Yes No
- multiple sclerosis..... Yes No
- tragedian neuralgia..... Yes No
- chronic pain..... Yes No
- anxiety/depression..... Yes No
- alzheimer's diseas/dementia.... Yes No
- psychiatric treatment..... Yes No
- psychological counseling..... Yes No
- persistent dizziness/fainting.... Yes No
- persistent numbness/tingling... Yes No
- other nervous/mental disorder: _____

Head & Neck

- glaucoma..... Yes No
- chronic sinusitis..... Yes No
- injury head/neck/jaw/teeth.... Yes No
- headaches/migranes..... Yes No
- recurrent neck pain..... Yes No
- frequent nose bleeds..... Yes No
- other head/neck disorder _____

Musculoskeletal/Connective Tissue

- sjogren's syndrome..... Yes No
- arthritis..... Yes No
- artificial joint (Year ____). Yes No
- fibromyalgia/rehumatism..... Yes No
- chronic back pain..... Yes No
- other muscle/bone disorder: _____

Respiratory

- tuberculosis (TB)..... Yes No
- asthma..... Yes No
- chronic bronchitis..... Yes No
- emphysema..... Yes No
- persistent cough..... Yes No
- cough up bloody sputum..... Yes No
- shortness of breath..... Yes No
- other respiratory disorde _____

Urinary Tract

- kidney disease..... Yes No
- renal dialysis..... Yes No
- venereal disease..... Yes No
- sexually transmitted disease... Yes No
- other urinary disorder: _____

Endocrine

- diabetes..... Yes No
- thyroid/goiter..... Yes No
- other endocrine disorder: _____

Digestive System

- hepatitis..... Yes No
- cirrhosis of liver..... Yes No
- liver disease..... Yes No
- ulcers..... Yes No
- jaundice..... Yes No
- frequent heart burn/reflux..... Yes No
- frequent nausea/vomiting..... Yes No
- other digestive disorder: _____

Cancer History

- cancer..... Yes No
- if yes, what type: _____
- leukemia..... Yes No
- benign tumors/growths..... Yes No
- type of treatments: _____
- surgery..... Yes No
- radiation therapy..... Yes No
- chemotherapy..... Yes No
- hormone therapy..... Yes No

Allergy History

- Are you allergic to or have you had a bad reaction to any of the following?
- dental anesthetics..... Yes No
- penicillin..... Yes No
- sulfa drugs..... Yes No
- aspirin..... Yes No
- latex products..... Yes No
- metals (including jewelry).. Yes No
- other antibiotics: _____
- other allergy: _____

Family History

- Has anyone in your family ever had:
- diabetes..... Yes No
- heart disease..... Yes No
- depression or anxiety..... Yes No
- tuberculosis..... Yes No
- any disorder that "runs" in your family?

Please continue on the other side →



St. Mary Dental

Name:	Date of Birth	Chart #
--------------	----------------------	----------------

HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

Please answer each question, check yes or no. If in doubt, leave blank.

Miscellaneous lupus erythematosus..... Yes No organ transplant..... Yes No if yes, which organ? _____ suppressed immune system..... Yes No persistent fever..... Yes No taken steroids/prednisone..... Yes No tested positive for HIV..... Yes No diagnosed with AIDS..... Yes No taken prescription diet pills.... Yes No if yes, please check type <input type="checkbox"/> pondimin <input type="checkbox"/> redux <input type="checkbox"/> phen-fen <input type="checkbox"/> other: _____	Miscellaneous (Con't) used tobacco products..... Yes No if yes, what type? _____ how much? _____ How long? _____ still using tobacco?..... Yes No would you like to quit?..... Yes No drink alcoholic beverages..... Yes No if yes, how much? _____ used methamphetamine, amphetamines or "speed"..... Yes No used intravenous drugs..... Yes No used cocaine or "crack"..... Yes No used any other drugs: _____ are you a recovering addict?.... Yes No	Women Only are you pregnant?..... Yes No are you breast feeding?..... Yes No are you in menopause?..... Yes No
--	--	--

Do you have any other conditions that you think we should be made aware of? Yes No if yes, please list: _____

Please circle and list medications your are currently taking, include over the counter medications, herbal and nutritional supplements:

steriods/cortisone	heart	antihistamine	hormones	tranquilizers
nitroglycerin	pain	cyclosporine A	nifedipine	anti depressants
oral contraceptive	aspirin	blood thinners	antibiotics	digitalis
insulin/diabetic drugs	thyroid	blood pressure		

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have completed this health history questionnaire to the best of my ability. I will notify Dr. Basta and/or St. Mary Dental staff if any changes occur in my health and/or medications I am currently taking.

Signature of Patient, Parent or Legal Guardian _____ Date _____

Health Updates (must be review every six (6) months or more often as indicated)

Date	Changes to Health History	Patient Signature

Note: A new Health History Questionnaire should be completed at least every two (2) years; more often if indicated or if all updates have been used.