

CONFIDENTIAL HEALTH HISTORY

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

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

- 1. Yes No Is your general health good?
If NO, explain _____
- 2. Yes No Has there been a change in your health within the last year?
If YES, explain _____
- 3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
- 4. Yes No Are you being treated by a physician now? If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
- 5. Yes No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
- 6. Yes No Are you in pain now? If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|--------------------------------|--------------------------|-------------------------|
| Chest pain (angina) | Blood in stools | Frequent vomiting |
| Fainting spells | Diarrhea or constipation | Jaundice |
| Recent significant weight loss | Frequent urination | Dry mouth |
| Fever | Difficulty urinating | Excessive thirst |
| Night sweats | Ringing in ears | Difficulty swallowing |
| Persistent cough | Headaches | Swollen ankles |
| Coughing up blood | Dizziness | Joint pain or stiffness |
| Bleeding problems | Blurred vision | Shortness of breath |
| Blood in urine | Bruise easily | Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|---------------------------------|---------------------------------|------------------------------|
| Heart disease | AIDS/HIV | Psychiatric care |
| Family history of heart disease | Surgeries | Osteoporosis |
| Heart attack | Hospitalization | Thyroid disease |
| Artificial joint | Diabetes | Asthma |
| Stomach problems or ulcers | Family history of diabetes | Hepatitis (type: _____) |
| Heart defects | Tumors or cancer | Sexually transmitted disease |
| Heart murmurs | Chemotherapy | Herpes |
| Rheumatic fever | Radiation | Canker or cold sores |
| Skin disease | Arthritis/rheumatism | Anemia |
| Hardening of arteries | Emphysema or other lung disease | Liver disease |
| Pacemaker | Glaucoma | Blood transfusions |
| High blood pressure | Kidney or bladder disease | Eye disease |
| Seizures or Epilepsy | Stroke | Transplants |
| Cosmetic surgery | Eating disorders | Tuberculosis (PPD positive) |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|------------------|--------------|--------------|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |
- Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

- | | | |
|----------------------------|--------------------------|-------------|
| Recreational drugs | Tobacco in any form | Antibiotics |
| Over-the-counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |
- Please list medications: _____
- _____

VI. ADDITIONAL MEDICAL HISTORY

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____
Yes No Have you ever taken Fen-phen? If YES, when _____
Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

VII. WOMEN ONLY

Yes No Are you or could you be pregnant? If YES, what month? _____
Yes No Are you nursing?
Yes No Are you taking birth control pills?

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' Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

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 Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dental Provider Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact (name and telephone number): _____