Health History

Patient Name:_____

Name of Medical Doctor: _____ City/State: _____

I. Please mark YES or NO for the following questions:

YES	NO	
☐	☐	Is your General over all health good?
☐	☐	Has there been a change in your health within the last year?
		If YES, why? _____
☐	☐	Are you being treated by a physician now? For what? _____
		Date of last medical exam? _____ Date of last dental exam? _____
		List any allergies to medication or other: _____
☐	☐	Have you had problems with any prior dental treatment?
☐	☐	Are you in pain now?

II. Have you experienced:

YES	NO		YES	NO	
☐	☐	Chest pain?	☐	☐	Dizziness?
☐	☐	Swelling in feet,ankles, hands?	☐	☐	Ringing in ears?
☐	☐	Shortness of breath?	☐	☐	Headaches or blurred vision?
☐	☐	Recent weight loss, fever, night sweats?	☐	☐	Fainting spells?
☐	☐	Persistant cough, coughing up blood?	☐	☐	Sinus problems?
☐	☐	Bleeding problems, bruising easily?	☐	☐	Seizures?
☐	☐	Difficulty swallowing?	☐	☐	Excessive thirst?
☐	☐	Diarrhea, constipation, blood in stools?	☐	☐	Dry mouth?
☐	☐	Frequent vomiting, nausea?	☐	☐	Jaundice?
☐	☐	Difficult or frequent urination, blood in urine?	☐	☐	Joint pain, stiffness?

III. Do you have or have you had:

YES	NO		YES	NO	
☐	☐	Heart disease?	☐	☐	AIDS?
☐	☐	Heart attack, Heart defects?	☐	☐	Arthritis, rheumatism?
☐	☐	Heart murmurs?	☐	☐	Eye disease?
☐	☐	Rheumatic fever?	☐	☐	Skin disease?
☐	☐	Stroke, hardening of arteries?	☐	☐	Anemia?
☐	☐	High blood pressure?	☐	☐	VD (syphilis or gonorrhea)?
☐	☐	Asthma, TB, emphysema, other lung disease?	☐	☐	Herpes?
☐	☐	Hepatitis, other liver disease?	☐	☐	Kidney, bladder disease?
☐	☐	Stomach problems, ulcers?	☐	☐	Thyroid, adrenal disease?
☐	☐	Tumors, Cancer?	☐	☐	Diabetes?

IV. Do you have or have had:

YES	NO		YES	NO	
☐	☐	Psychiatric care?	☐	☐	Hospitalization?
☐	☐	Radiation treatment?	☐	☐	Blood transfusions?
☐	☐	Chemotherapy?	☐	☐	Surgeries?
☐	☐	Prosthetic heart valve?	☐	☐	Pacemakers?
☐	☐	Artificial joint?	☐	☐	Contact lenses?

V. Are you taking:

YES	NO		YES	NO	
☐	☐	Recreational Drugs?	☐	☐	Tobacco in any form?
☐	☐	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	☐	☐	Alcohol?

Please list: _____

VI: Additional information:

☐ ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

VII. Women only:

YES	NO		YES	NO	
☐	☐	Are you or could you be pregnant or nursing?	☐	☐	Taking birth control pills?

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.

signature_____ Date: