David L. Rens, DDS
Ann Marie Zimmerman, DDS

CONFIDENTIAL HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

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

Yes No Is your general health good? If NO, Why? _____

Yes No Have there been a change in your health in the last year?

Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

Yes No Are you being treated by a physician now?

Yes No Have you had problems with prior dental treatment?

How long since last dental exam: _____ Name of last dentist: _____

Yes No Are you in pain now? If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

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

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

- Heart disease
- Family history of heart disease
- Heart attack
- Artificial joint
- Stomach problems or ulcers
- Heart defects
- Heart murmurs
- Rheumatic fever
- Skin disease
- Hardening of arteries
- High blood pressure
- Seizures
- Cosmetic surgery
- AIDS/HIV
- Surgeries
- Hospitalization
- Diabetes
- Family history of diabetes
- Tumors or cancer
- Chemotherapy
- Radiation
- Arthritis, rheumatism
- Emphysema/lung disease
- Kidney or bladder disease
- Stroke
- Eating disorders
- Psychiatric care
- Osteoporosis
- Thyroid disease
- Asthma
- Hepatitis
- Sexual transmitted disease
- Herpes
- Canker or cold sores
- Anemia
- Liver disease
- Eye disease
- Transplants
- Tuberculosis

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

- Aspirin
- Darvon
- Codeine
- Local anesthetic (Novocaine/Lidocaine)
- Nitrous oxide
- Valium
- Demerol
- Penicillin
- Latex
- Erythromycin
- Tetracycline
- Vicodin
- Percodan
- Metal (Nickel)
- Other

V. HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS?

- ☐ Tobacco in any form
- ☐ Alcohol
- ☐ Biophosphonates (Fosamax)
- ☐ Antibiotics
- ☐ Supplements
- ☐ Aspirin
- ☐ Over-the-counter medications
- ☐ Weight Loss Medications
- ☐ Recreational Drugs

Please List: _____

VI.MEDICATIONS - Including Supplements

Medication	Dose	Frequency	Medication	Dose	Frequency

VI. WOMEN ONLY

- ◯ Yes ◯ No Are you pregnant? If YES, what week? ☐
- ◯ Yes ◯ No Are you nursing?
- ◯ Yes ◯ No Are you taking birth control pills?

VII. ALL PATIENTS

- ◯ Yes ◯ No Do you have any other diseases or medical conditions NOT listed on this form?
  If YES, what? _____
- ◯ Yes ◯ No Have you ever been pre-medicated for dental treatment?
  If YES, why? _____
- ◯ Yes ◯ No Have you ever taken the diet pill Fen-phen?
- ◯ Yes ◯ No ***Is there any issue or condition you would like to discuss in private with the doctor?***

Print Form

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 Signature (or Guardian if a minor): X _____ Date: _____

Physician's Name: _____ Physician's 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.

Patient's Signature (or Guardian if a minor): X _____ **Date:** _____

Signature of Dentist: _____ **Date:** _____

MEDICAL UPDATES

DATE	CHANGES TO HEALTH HISTORY & MEDICATIONS	Dr. INITIALS