T H E O D O R E A. T A N A B E, D. D. S.

HEALTH HISTORY

Name: _____ Date: _____

Date of birth: _____ Sex: M F Height: _____ Weight: _____

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will remain confidential.

Are you in good health? YES NO
Has there been any change in your health in the past year? YES NO
My last physical exam was on _____
Are you now under the care of a physician? YES NO
If so, for what condition? _____
Have you had any serious illness, significant operation or hospitalization in the last 5 years? YES NO
If so, for what condition? _____

Do you have or have you had any of the following diseases or problems?			NOTES
Damaged heart valves, artificial valves or heart murmur	YES	NO	
Rheumatic heart disease	YES	NO	
Heart trouble or heart attack	YES	NO	
Chest pain or angina	YES	NO	
Irregular heart beat	YES	NO	
Cardiac pacemaker	YES	NO	
Heart surgery	YES	NO	
High blood pressure	YES	NO	
Stroke	YES	NO	
Arteriosclerosis	YES	NO	
Do you have any prosthetic joints?	YES	NO	
Sinus problems	YES	NO	
Asthma or hay fever	YES	NO	
Fainting spells	YES	NO	
Diabetes	YES	NO	
Hepatitis, jaundice, or liver disease	YES	NO	
Frequent or recurring mouth sores	YES	NO	
Thyroid problems	YES	NO	
Respiratory problems, emphysema, or bronchitis	YES	NO	
Arthritis or painful, swollen joints including the jaw joint (TMJ)	YES	NO	
Stomach ulcer or hyperacidity	YES	NO	
Kidney problems or dialysis	YES	NO	
Phen-fen or other diet medicines	YES	NO	
Tuberculosis	YES	NO	
Persistent cough or a cough that produces blood	YES	NO	
Persistent swollen neck glands	YES	NO	
Epilepsy, seizures, or neurological disorders	YES	NO	
Cancer	YES	NO	
Radiation therapy or chemotherapy	YES	NO	
Has any disease, drug, or surgery depressed your immune system?	YES	NO	
Abnormal bleeding, anemia or blood disorder	YES	NO	
Have you ever required a blood transfusion?	YES	NO	
Bisphosphonate therapy (Aredia, Zometa, Fosamax, or others)	YES	NO	
Have you ever had treatment for a tumor or growth?	YES	NO	
Do you smoke?	YES	NO	
Drug or alcohol abuse	YES	NO	
Eye disease or glaucoma	YES	NO	
Mental health problems	YES	NO	

Have you ever had any serious trouble associated with previous dental treatment? YES NO
If so, please explain: _____

Do you have any other condition or disease you think the doctor should know about? YES NO
If so, please explain: _____

Are you wearing contact lenses? YES NO
Are you wearing removable dental appliances? YES NO
Do you wish to talk with the doctor privately about anything? YES NO

MEDICATIONS

Please list any medicine(s) you are currently taking including non-prescription, homeopathic or "natural" remedies including diet pills:

ALLERGIES

Have you ever had a reaction to any of the following?

Penicillin or amoxicillin	YES	NO	Local anesthetics (novacaine, etc.)	YES	NO
Sulfa drugs	YES	NO	Barbiturates or sleeping pills	YES	NO
Erythromycin	YES	NO	Iodine	YES	NO
Other antibiotic(s)	YES	NO	Latex or rubber products	YES	NO
			Allergies other than to drugs	YES	NO
Aspirin	YES	NO			
Codeine or other narcotics	YES	NO	Allergies to other medications	YES	NO

WOMEN

Are you pregnant or trying to become pregnant? YES NO
Are you nursing? YES NO
Are you taking birth control pills? YES NO

CHIEF DENTAL COMPLAINT

My main dental concern is: _____

I certify that I have read and understand the information documented above. I acknowledge that my questions, if any, about any items listed above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient/guardian signature: _____

Date: _____ Doctor's signature: _____

*** RECALL PATIENTS ONLY ***

I certify that I have reviewed the documented medical history and list of medications above, and I have indicated any changes. I acknowledge that my questions, if any, about any items listed above have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient/guardian signature: _____

Date: _____ Doctor's signature: _____

Date: _____ Patient/guardian signature: _____

Date: _____ Doctor's signature: _____