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 3 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 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 check)**

Yes	No		Yes	No		Yes	No	
☐	☐	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 check)

Yes	No		Yes	No		Yes	No	
☐	☐	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
☐	☐	Heart defects	☐	☐	Tumors or cancer	☐	☐	Sexual transmitted disease
☐	☐	Heart murmur	☐	☐	Chemotherapy	☐	☐	Herpes
☐	☐	Rheumatic fever	☐	☐	Radiation	☐	☐	Canker or cold sores
☐	☐	Skin disease	☐	☐	Arthritis, Rheumatism	☐	☐	Anemia
☐	☐	Hardening of arteries	☐	☐	Emphysema or other lung disease	☐	☐	Liver disease
☐	☐	High blood pressure	☐	☐	Kidney or bladder disease	☐	☐	Eye disease
☐	☐	Seizures	☐	☐	Stroke	☐	☐	Transplants
☐	☐	Cosmetic surgery	☐	☐	Eating disorders	☐	☐	Tuberculosis

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

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Valium	☐	☐	Tetracycline
☐	☐	Darvon	☐	☐	Demerol	☐	☐	Vicodin
☐	☐	Codeine	☐	☐	Novocain or Xylocaine	☐	☐	Percodan
☐	☐	Nitrous oxide	☐	☐	Latex	☐	☐	Food
☐	☐	Penicillin	☐	☐	Nut	☐	☐	Metal
☐	☐	Erythromycin						

Others: ______________________________

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

Yes	No		Yes	No		Yes	No	
☐	☐	Recreational drugs	☐	☐	Tobacco in any forms	☐	☐	Antibiotics
☐	☐	Over-the-counter medicines	☐	☐	Alcohol	☐	☐	Supplements
☐	☐	Weight loss medication	☐	☐	Bisphosphonate (Fosamax)	☐	☐	Aspirin

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

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____

____

VI. 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?

VII. ALL PATIENTS

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?**

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: X___________________ Date: ___________________

Physician's name: ___________________ Phone number: ___________________

Physician's address: ___________________

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 medications. 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.

X X

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

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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	DENTIST INITALS