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HEALTH HISTORY

HEALTH INFORMATION

PLEASE PRINT

Date _____

Patient's Name _____ Date of Birth _____

If completing this form for another person, what is your name and relationship to that person?

Is there anything you wish to discuss in private with the doctor? Yes _____ No _____

For the following questions, **circle Yes or No**. Your answers are for our records only and will be kept confidential.

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| <p>1. Are you in good health? Yes No</p> <p>2. Has there been any change in your general health within the past year? Yes No</p> <p>Have you ever had or do you now have?</p> <p>3. Pacemaker Yes No</p> <p>4. Heart Murmur Yes No</p> <p>5. Mitral valve prolapse Yes No</p> <p>6. Rheumatic heart disease Yes No</p> <p>7. Damaged heart valve Yes No</p> <p>8. Heart trouble Yes No</p> <p>9. Heart attack Yes No</p> <p>10. Angina Yes No</p> <p>11. High Blood Pressure Yes No</p> <p>12. Arteriosclerosis (hardening of the arteries) Yes No</p> <p>13. Stroke Yes No</p> <p>14. Chest pain upon exertion Yes No</p> <p>15. Shortness of breath after mild exercise or when lying down? Yes No</p> <p>16. Swollen ankles Yes No</p> <p>17. Congenital heart defect Yes No</p> <p>18. Prosthetic (artificial) heart valve Yes No</p> <p>19. Allergy Yes No</p> <p>20. Sinus trouble Yes No</p> <p>21. Asthma or hay fever Yes No</p> <p>22. Fainting spells or seizures Yes No</p> <p>23. Persistent diarrhea or recent weight loss Yes No</p> <p>24. Diabetes Yes No</p> <p>25. Hepatitis, jaundice or liver disease Yes No</p> <p>26. AIDS or HIV infection Yes No</p> <p>27. Thyroid problems Yes No</p> <p>28. Respiratory problems, emphysema, bronchitis, etc. Yes No</p> | <p>29. TB, Tuberculosis (Self, Family, Household) Yes No</p> <p>30. Persistent cough/ cough that produces blood Yes No</p> <p>31. Arthritis or painful/swollen joints Yes No</p> <p>32. Artificial joint replacement Yes No</p> <p>33. Stomach ulcer or hyperacidity Yes No</p> <p>34. Kidney trouble or dialysis Yes No</p> <p>35. Persistent swollen glands in neck Yes No</p> <p>36. Sexually transmitted disease Yes No</p> <p>37. Epilepsy or other neurological disease Yes No</p> <p>38. Psychotherapy Yes No</p> <p>39. Problems with mental health Yes No</p> <p>40. Cancer Yes No</p> <p>41. Problems of the immune system Yes No</p> <p>42. Rheumatic fever or scarlet fever Yes No</p> <p>43. Abnormal bleeding Yes No</p> <p>44. Blood transfusion Yes No</p> <p>45. Blood disorders such as anemia Yes No</p> <p>46. Tumor or growth Yes No</p> <p>47. Allergic or other reaction to</p> <p style="padding-left: 20px;">a. local anesthetics or dental anesthetics Yes No</p> <p style="padding-left: 20px;">b. Penicillin or other antibiotics Yes No</p> <p style="padding-left: 20px;">c. Sulfa drugs Yes No</p> <p style="padding-left: 20px;">d. Barbiturates, sedatives, or sleeping pills ... Yes No</p> <p style="padding-left: 20px;">e. Aspirin Yes No</p> <p style="padding-left: 20px;">f. Codeine Yes No</p> <p style="padding-left: 20px;">g. Other Yes No</p> <p>Women</p> <p>48. Are you pregnant? Yes No</p> <p>49. Do you have any problems associated with your menstrual period? Yes No</p> <p>50. Are you nursing? Yes No</p> |
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Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:

Are you taking any medications (including non prescription)? _____

Tobacco use: Current Past Never used Type _____ Amount per day _____ Date tobacco use stopped _____

Alcohol use: Current Past Never used Describe usage:

Names of your primary health care practitioners (MD, DC, DO, etc.):

Name _____ Specialty _____ City _____

Name _____ Specialty _____ City _____

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Date