

Confidential Health History

Patient Name: _____ Date of Birth: _____

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

1. Y / N Is your general health good?
If NO, explain: _____
2. Y / N Has there been a change in your health within the last year?
If YES, explain: _____
3. Y / N Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain: _____
4. Y / N Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam? _____ Reason for exam: _____
5. Y / N Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____
6. Y / N Are you in pain now?
If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

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

Other: _____

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

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

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please choose Yes or No for each)

- | | | |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y/ <input type="checkbox"/> N Valium or other sedatives | <input type="checkbox"/> Y/ <input type="checkbox"/> N Codeine or other narcotics |
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Penicillin or other antibiotics | <input type="checkbox"/> Y/ <input type="checkbox"/> N Latex | <input type="checkbox"/> Y/ <input type="checkbox"/> N Food |
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Nitrous oxide | <input type="checkbox"/> Y/ <input type="checkbox"/> N Local anesthetic | <input type="checkbox"/> Y/ <input type="checkbox"/> N Metal |

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please choose Yes or No for each)

- | | | |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Recreational drugs | <input type="checkbox"/> Y/ <input type="checkbox"/> N Tobacco in any form | <input type="checkbox"/> Y/ <input type="checkbox"/> N Antibiotics |
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Over-the-counter medicines | <input type="checkbox"/> Y/ <input type="checkbox"/> N Alcohol | <input type="checkbox"/> Y/ <input type="checkbox"/> N Supplements |
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Weight loss medications | <input type="checkbox"/> Y/ <input type="checkbox"/> N Bisphosphonate (Fosamax) | <input type="checkbox"/> Y/ <input type="checkbox"/> N Aspirin |
| <input type="checkbox"/> Y/ <input type="checkbox"/> N Anti-Depressants | <input type="checkbox"/> Y/ <input type="checkbox"/> N Herbal Supplements | |

Please list all prescription medications: _____

VI. WOMEN ONLY (Please choose Yes or No for each)

- Y/ N Are you or could you be pregnant? If YES, what month? _____
- Y/ N Are you nursing?
- Y/ N Are you taking birth control pills?

VII. ALL PATIENTS (Please choose Yes or No for each)

- Y/ N Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
- Y/ N Have you ever been pre-medicated for dental treatment? If YES, why: _____
- Y/ N Have you ever taken Fen-Phen? If YES, when: _____
- Y/ N 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's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name : _____ Relationship : _____ 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.

Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date

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 INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____