

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 three years? If YES, explain:

4. Yes No Are you being treated by a physician now? If YES, explain:

5. Yes No Date of last medical exam? _____ Reason for exam: _____
Have you had problems with prior dental treatment? If YES, explain:

6. Yes No Date of last dental exam _____
Name of last treating dentist _____
Are you in pain now? If YES, explain:

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

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

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

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

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

- | | | |
|---|--------------|--------------|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic (Novacaine or Xylocaine) | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |
| Others: | | |

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

| | | |
|----------------------------|--------------------------|-------------|
| Recreational drugs | Tobacco, in any form | Antibiotics |
| Over-the-counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |

Please list:

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?

VI. 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?
If YES, please explain:

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: _____

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.

Signature of Patient (Parent or Guardian): _____ Date: _____

CHANGES TO HEALTH HISTORY:

| Date | Signature | Changes | Dentist Initial |
|-------|-----------|---------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |