

PATIENT HEALTH HISTORY

Your Name: _____ **Date of Birth:** _____
Physician's Name: _____ **Physician's Phone:** _____ **Medical/Kaiser #** _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

(Please Circle)

Are you under a physician's care now? YES NO If yes, please explain _____
 Have you ever been hospitalized or had a major operation? YES NO If yes, please explain _____
 Have you ever had a serious head or neck injury? YES NO If yes, please explain _____
 Do you, or have you ever taken Phen-Fen or Redux? YES NO
 Do you or have you ever taken **Fosamax** or similar medication? YES NO
 Do you smoke or use tobacco? YES NO
 Do you use controlled substances? YES NO

WOMEN: Are you _____ *(please circle)* _____ *(please circle)* _____ *(please circle)* _____
 Pregnant/ Trying to get pregnant? YES NO Taking Oral Contraceptives? YES NO Nursing? YES NO

Are you allergic to any of the following? *(please check all that apply)*
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain _____

Please list all medications you are currently taking:
 _____ reason _____ _____ reason _____
 _____ reason _____ _____ reason _____

Do you have, or have you ever had, any of the following: *(please circle)*

AIDS / HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Disease	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives / Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Disease		
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Tumors/Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Yellow Jaundice	Yes	No

(please circle)

Have you ever had any serious illness not listed above? Yes No If yes, explain _____
Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's Signature _____ **Date** _____
Dentist's Signature _____ **Date** _____

