

# Health History

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

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

- |  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health?   | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you had any abnormal bleeding?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year?  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bruise easily?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: _____  |                          |                          | 11. Have you ever required a blood transfusion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physician's name _____<br>Address _____<br>Phone No. _____  |                          |                          | 12. Have you had a recent weight loss?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician?  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness?<br>Please explain. _____               | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medicine(s) including non-prescription medicine?<br>If yes, what medicine(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you use alcohol or cocaine or other drugs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken Fen-Phen/Redux?   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you wearing contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 17. Do you have any disease, condition or problem not listed above that you think I should know about?                 | <input type="checkbox"/> | <input type="checkbox"/> |

**Women Only:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you nursing?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking birth control pills?            | <input type="checkbox"/> | <input type="checkbox"/> |

e-mail address: \_\_\_\_\_

- |  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <b>Are you allergic to or have you had reactions to:</b> |                          |                          | 8. Low blood pressure?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Local anesthetics like novocaine?                     | <input type="checkbox"/> | <input type="checkbox"/> | 9. Hepatitis, jaundice or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Penicillin or other antibiotics?                      | <input type="checkbox"/> | <input type="checkbox"/> | 10. Stroke?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sulfa drugs?  | <input type="checkbox"/> | <input type="checkbox"/> | 11. Sinus trouble?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Barbiturates, sedatives or sleeping pills?            | <input type="checkbox"/> | <input type="checkbox"/> | 12. Lung or breathing problems?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aspirin?  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Asthma or hay fever?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Iodine?   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Hives or skin rash?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other? _____  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Fainting spells or seizures?         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Do you have or have you ever had the following:</b>   |                          |                          | 16. Diabetes?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Rheumatic heart disease or rheumatic fever?           | <input type="checkbox"/> | <input type="checkbox"/> | 17. AIDS or HIV infection?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Scarlet fever?  | <input type="checkbox"/> | <input type="checkbox"/> | 18. Thyroid problems?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart defect or heart murmur?                         | <input type="checkbox"/> | <input type="checkbox"/> | 19. Allergies?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Heart trouble, heart attack, or angina?               | <input type="checkbox"/> | <input type="checkbox"/> | 20. Arthritis or rheumatism?             | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Do you have pain in your chest upon exertion?         | <input type="checkbox"/> | <input type="checkbox"/> | 21. Joint replacement or implant?        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you ever short of breath after mild exercise?     | <input type="checkbox"/> | <input type="checkbox"/> | 22. Stomach ulcer?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do your ankles swell?                                 | <input type="checkbox"/> | <input type="checkbox"/> | 23. Kidney trouble?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you get short of breath when you lie down?         | <input type="checkbox"/> | <input type="checkbox"/> | 24. Tuberculosis?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Do you require extra pillows when you sleep?          | <input type="checkbox"/> | <input type="checkbox"/> | 25. Persistent cough?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Pacemaker?  | <input type="checkbox"/> | <input type="checkbox"/> | 26. Cough that produces blood?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Cancer?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. High blood pressure?                                  | <input type="checkbox"/> | <input type="checkbox"/> | 28. Sexually transmitted disease?        | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 29. Epilepsy?                            | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 30. Anemia?                              | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 31. Leukemia?                            | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 32. Glaucoma?                            | <input type="checkbox"/> | <input type="checkbox"/> |

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_