

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: _____
Date of last medical exam: _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | | | | |
|----------|--------------------------------|----------|--------------------------|----------|-------------------------|
| Yes / No | Chest pain (angina) | Yes / No | Blood in stools | Yes / No | Frequent vomiting |
| Yes / No | Fainting spells | Yes / No | Diarrhea or constipation | Yes / No | Jaundice |
| Yes / No | Recent significant weight loss | Yes / No | Frequent urination | Yes / No | Dry mouth |
| Yes / No | Fever | Yes / No | Difficulty urinating | Yes / No | Excessive thirst |
| Yes / No | Night sweats | Yes / No | Ringings in ears | Yes / No | Difficulty swallowing |
| Yes / No | Persistent cough | Yes / No | Headaches | Yes / No | Swollen ankles |
| Yes / No | Coughing up blood | Yes / No | Dizziness | Yes / No | Joint pain or stiffness |
| Yes / No | Bleeding problems | Yes / No | Blurred vision | Yes / No | Shortness of breath |
| Yes / No | Blood in urine | Yes / No | Bruise easily | Yes / No | Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | | | | |
|----------|---------------------------------|----------|---------------------------------|----------|----------------------------|
| Yes / No | Heart disease | Yes / No | AIDS/HIV | Yes / No | Psychiatric care |
| Yes / No | Family history of heart disease | Yes / No | Surgeries | Yes / No | Osteoporosis |
| Yes / No | Heart attack | Yes / No | Hospitalization | Yes / No | Thyroid disease |
| Yes / No | Artificial joint | Yes / No | Diabetes | Yes / No | Asthma |
| Yes / No | Stomach problems or ulcers | Yes / No | Family history of diabetes | Yes / No | Hepatitis |
| Yes / No | Heart defects | Yes / No | Tumors or cancer | Yes / No | Sexual transmitted disease |
| Yes / No | Heart murmurs | Yes / No | Chemotherapy | Yes / No | Herpes |
| Yes / No | Rheumatic fever | Yes / No | Radiation | Yes / No | Canker or cold sores |
| Yes / No | Skin disease | Yes / No | Arthritis, rheumatism | Yes / No | Anemia |
| Yes / No | Hardening of arteries | Yes / No | Emphysema or other lung disease | Yes / No | Liver disease |
| Yes / No | High blood pressure | Yes / No | Kidney or bladder disease | Yes / No | Eye disease |
| Yes / No | Seizures | Yes / No | Stroke | Yes / No | Transplants |
| Yes / No | Cosmetic surgery | Yes / No | Eating disorders | Yes / No | Tuberculosis |

(Continued on the next page)

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

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: _____

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

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list all prescription medications: _____

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

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? _____

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

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? _____

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 _____