HEALTH HISTORY

Purpose for visit _____

Is your physical health Excellent ☐ Good ☐ Fair ☐ Poor ☐

Is your dental health Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you have a current medical problem? No ☐ Yes ☐ Expl. _____

Are you allergic to any drugs or medication? No ☐ Yes ☐ Expl. _____

Are you currently taking any medications? No ☐ Yes ☐ Expl. _____

Please check which of the following conditions or diseases apply:

		Yes	No
Allergy	None ☐		
Hayfever		___	___
Insect bites		___	___
Medicine (Please list above)		___	___
Other _____		___	___
Blood Disorder	None ☐		
Anemia		___	___
Rheumatic Fever		___	___
Hemophilia		___	___
Bleeding tendency		___	___
Diabetes		___	___
Glaucoma		___	___
Other _____		___	___
Nervous Disorder	None ☐		
Seizure Disorder		___	___
Developmental Disorder		___	___
Hearing/Speech/Visual Disorder		___	___
Behavioral Disorder		___	___
Fainting Spells		___	___
Stroke Date if yes _____		___	___
Other _____		___	___
Tumor/Malignancy	None ☐		
Radiation Treatment		___	___
Chemotherapy		___	___
Surgery		___	___

		Yes	No
Heart Condition	None ☐		
Hypertension		___	___
Rheumatic Heart Disease		___	___
Murmur		___	___
Prolapsed valve		___	___
Septal defect		___	___
Heart attack - Date_____		___	___
Other _____		___	___
Kidney Disease	None ☐		
Dialysis		___	___
Kidney Stones		___	___
Other		___	___
Endocrine Disorder	None ☐		
Pituitary Gland		___	___
Thyroid Gland		___	___
Liver Disease		___	___
Other _____		___	___
Pulmonary	None ☐		
Asthma		___	___
Bronchitis		___	___
Emphysema		___	___
Shortness of breath		___	___
Other_____		___	___

Please explain any of the following which may apply:

Joint or heart valve replacement _____

Cancer/Tumor/Cyst _____

Infectious Diseases: AIDS, HIV, HEPATITIS, VENEREAL DISEASE, HERPES SIMPLEX, TUBERCULOSIS, MONONUCLEOSIS, OTHER _____

Have you used any diet medication such as? ☐ Fen-fen ☐ Redux

Do you smoke? Yes ☐ No ☐ How much?

Do you use alcohol (more than 2 drinks per day) Yes ☐ No ☐

(Women) Are you pregnant? Yes ☐ No ☐ What month _____

Have you ever been hospitalized? Yes ☐ No ☐ Explain _____

Have you ever had a blood transfusion? Yes ☐ No ☐ Explain_____

Signature_____Date_____

Update/Review

DATE	INIT.	DATE	INIT.
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____