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 EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain	Yes / No Blood in stools	Yes / No Frequent
Yes / No (angina) Fainting	Yes / No Diarrhea or	Yes / No vomiting
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 Ringing in ears	Yes / No Difficulty
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or
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

Other: ____

III. HAVE YOU EVER 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
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	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

Other: ____

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 or other	Yes / No Codeine or other
Yes / No Penicillin or other antibiotics	Yes / No sedatives Latex	Yes / No narcotics Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	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 Supplement
Yes / No Weight loss	Yes / No Bisphosphonate	Yes / No Aspirin
Yes / No medications Anti-	Yes / No (Fosamax) Herbal	

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: ______________________

Whom would you like us to contact in case of an emergency?

Name: ______________________ **Relationship**: ______________________ **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/Guardian) Date Signature of Dentist Date