HEALTH HISTORY

Patient's Name: _____ Date: _____

(Please ✔ Yes or No to each question. If unsure of a question, please consult with the dentist.)

	Yes	No
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____	☐	☐
Has there been any change in your general health in the past year? _____	☐	☐
2. Have you been hospitalized in the past two years? _____	☐	☐
3. When was your last visit to a Physician? _____		
Last complete physical examination? _____		
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? If yes, please list: 1._____ 2. _____ 3. _____ 4. _____ 5. _____	☐	☐
5. Have you ever reacted adversely to any of the following? (please circle) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills) CODINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, _____ any other medicine: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication? _____		
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies,	☐	☐
Skin Rashes, Hives, or any other allergic conditions? _____	☐	☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so please explain: _____	☐	☐
9. Has any family member had diabetes? _____	☐	☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____	☐	☐
11. Do your ankles, feet or hands swell? _____	☐	☐
12. Has your weight, appetite or energy level changed dramatically recently? _____	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
14. Do you follow a special diet? _____	☐	☐
15. Have you tested HIV positive? _____	☐	☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____	☐	☐
17. Have you ever had any injury or surgery to your face or jaws? _____	☐	☐
18. Do you wear eyeglasses or contact lenses? _____	☐	☐
19. Do you have any hearing difficulties? _____	☐	☐
20. Do you smoke or use any other forms of tobacco? _____	☐	☐
Are you wearing the transdermal nicotine patch? _____	☐	☐
21. Are you alcohol and/or drug dependent? _____	☐	☐
and, Have you received treatment? _____	☐	☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD: _____	☐	☐

Yes	No		Yes	No		Yes	No	
☐	☐	A.I.D.S	☐	☐	Congential heart lesions	☐	☐	heart murmur
☐	☐	Anemia	☐	☐	Cortisone/steriod	☐	☐	Heart pacemaker
☐	☐	Angina pectoris	☐	☐	Diabetes	☐	☐	Heart rhythm disorder
☐	☐	Arthritis/rheumatism	☐	☐	Emphysema	☐	☐	Heart surgery
☐	☐	Artificial heart valve	☐	☐	Epilepsy or seizures	☐	☐	Hepatitis A
☐	☐	Artificial joints (hip, knee)	☐	☐	Fainting or dizzy spells	☐	☐	Hepatitis B
☐	☐	Blood disorders	☐	☐	Glandular disorders	☐	☐	Hepatitis C
☐	☐	Bronchitis	☐	☐	Glaucoma	☐	☐	Herpes
☐	☐	Cancer	☐	☐	Head/neck injuries	☐	☐	High/low blood pressure
☐	☐	Circulation Problems	☐	☐	Heart disease or attack	☐	☐	Hodgkins disease

Yes	No		Yes	No		Yes	No	
☐	☐	Hyper (Hypo) Glycemia	☐	☐	Medical implant	☐	☐	Thyroid disease
☐	☐	Hyertension	☐	☐	Psychiatric treatment	☐	☐	Tuberculosis
☐	☐	Jaundice	☐	☐	Radiation treatment	☐	☐	Ulcers
☐	☐	Kidney disease	☐	☐	Chemotherapy	☐	☐	Venereal disease
☐	☐	Liver disease	☐	☐	Rheumatic/Scarlet fever	☐	☐	Other_____
☐	☐	Lung disease	☐	☐	Sickle cell disease	☐	☐	Other_____
☐	☐	Malignant Hyperthermia	☐	☐	Sinus trouble	☐	☐	Other_____
☐	☐	Mental/nervous disorder	☐	☐	Stomach problems	☐	☐	Other_____
☐	☐	Mitral valve prolapse	☐	☐	Intestinal problems	☐	☐	
☐	☐	Organ transplant	☐	☐	Stroke	☐	☐	

23. Has the **CHILD PATIENT** ***recently*** had any of the following: (indicate approximate date)

☐	☐	Measles	☐	☐	Strep throat
☐	☐	Mumps	☐	☐	Tonsilitis
☐	☐	Chicken Pox	☐	☐	Other_____

24. **WOMEN ONLY** Are you pregnant or suspect you may be? ☐ ☐

If yes, what is the expected delivery date?_____ Are you taking birth control pills? yes ☐ no ☐

25. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?
yes ☐ no ☐ _____

26. Is there anything else about your health we should be made aware of? _____

27. Do you wish to speak to the Doctor privately about any problem or medical condition? yes ☐ no ☐

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents in mine, and I assume responsibility for fees associated with these services.

X_____ _____

☐ PATIENT ☐ PARENT ☐ GUARDIAN (PRINT NAME OF GUARDIAN)

Doctor's comments: _____

_____

_____

_____

_____

_____

_____

Reviewed by Treating Dentist:_____ Date: _____