HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (Leave BLANK if you do not understand question).

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last Medical Exam? _____ Date of last Dental Appt.?_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED?

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE HAD?

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver diseases?
37. Yes No Stomach problems, ulcers?
38. Yes No ALLERGIES: to drugs, foods, medications?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS or ARC?
41. Yes No Tumors cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases
44. Yes No Skin diseases?
45. Yes No Anemia?

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46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE YOU HAD?

51. Yes No Psychiatric care?
52. Yes No Radiation treatment?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING?

61. Yes No Recreational drugs?
62. Yes No Drugs, medicines (incl. Aspirin)?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please list: _____

_____

VI. WOMEN ONLY

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS

67. Yes No Do you have or have had any other disease or medical problems NOT listed on this form? _____

If so please explain: _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A ✓

- ☐ Teeth sensitive to cold, heat, sweets or pressure?
- ☐ Bleeding gums, How long?
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Complications from extractions
- ☐ Periodontal (gums) treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Fluoride treatments

CONSENT FOR TREATMENT: I hereby authorize to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

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.

Patient's Signature _____ Date _____

RECALL REVIEW

1. Patient's Signature _____ Date _____
2. Patient's Signature _____ Date _____
3. Patient's Signature _____ Date _____