HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ PHYSICIAN'S ADDRESS _____ PHYSICIAN'S PHONE _____

MOST RECENT VISIT TO PHYSICIAN _____ REASON _____

HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? O GOOD O FAIR O POOR

OFFICE USE ONLY

	YES	NO
PRE-MED	O	O

COMMENTS:

DATE _____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	O	O
Have you been hospitalized within the last year? If yes, explain:	O	O
Have you had a serious illness or operation within the last year? If yes, explain:	O	O
Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:	O	O
Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	O	O

Diabetes **yes** O **no** O

If yes, do you require insulin?
Type _____ Dose_____

Artificial joint(s) **yes** O **no** O

If yes, which joint(s)
_____

Hepatitis **yes** O **no** O

If yes, check type:

O Type A O Other
O Type B O Non-specific type
O Type C O Don't know

O Required a blood transfusion
If yes, when _____

O HIV positive
O Have reason to suspect you have been exposed to the HIV virus

Do you now or have you had any of the following cardio-vascular diseases? **yes** O **no** O

If yes, check any that apply:

O Heart disease
O Heart attack
O Coronary bypass
O Angina
O Mitral valve prolapse
O Hardening of the arteries
O High blood pressure
O Stroke
O Heart murmur
O Congestive heart failure

O Rheumatic fever or rheumatic heart disease
O Congenital heart defects
O Prosthetic (artificial) heart valves
O Pacemaker. If yes, date of placement _____
O High blood pressure
O High cholesterol
O Shortness of breath after mild exercise
O Shortness of breath when you lie down
O Swelling of ankles

Tuberculosis (TB) **yes** O **no** O

O Had a TB test?
O A cough lasting more than three weeks
O Cough up blood

Check any that apply;

O Allergies
O Alzheimer's
O Anemia
O Angina
O Asthma
O Arthritis
O Autoimmune
O Blood Disorder
O Cancer
O Chemo Therapy
O Chronic Sinus
O Cirrhosis
O Depression
O Glaucoma
O Heart Disease
O Herpes
O HIV / AIDS
O Jaundice
O Joint Replacement
O Kidney Disease
O Organ Transplant
O Osteoporosis
O Parkinson's
O Radiation
O Treatment
O Severe Headaches

HEALTH HISTORY

Do you consider yourself currently under an *abnormally* high amount of stress? Yes o No o

Have you had an unexplained or unplanned weight loss recently? Yes o No o

When was your last complete physical exam with your physician, including blood tests? _____

Do you now or have you ever smoked? o o
If you currently smoke, how much? _____
If you were a smoker, when did you quit? _____

Do you chew tobacco? o o
If yes, how often? _____

Do you drink alcohol? o o

W O M E N O N L Y

Are you currently pregnant? Yes o No o
If yes, expected delivery date _____

Do you have regular gynecological checkups? o o
Have you reached menopause? o o
Are you on hormone replacement therapy? o o
Have you had a mammogram? o o
Date _____

If you *currently* take these medications, check the box on the left. If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right and list them on the back of this form.

o Antibiotics	o
o Antidepressants (Prozac, Zoloft, etc.)	o
o Antihistamines	o
o Blood pressure medication	o
o Blood thinners	o
o Cortisone (Prednisone)	o
o Cholesterol medication	o
o Decongestants	o
o Diuretics (water pills)	o
o Hormones (birth control, estrogen)	o
o Inhalants	o
o Insulin	o
o Heart medication / nitroglycerine	o
o Muscle relaxants	o
o Pain medication (Aspirin, Advil, Tylenol)	o
o Sleeping pills	o
o Thyroid medication	o
o Tranquilizers	o

Are you *ALLERGIC* to any of the following (get hives, a rash, have trouble breathing, etc.):

o Antibiotics (penicillin, tetracycline)
o Local dental anesthetics (novocain)
o Codeine
o Aspirin
o Barbiturates or sedatives
o Tranquilizers
o Others (Please List All Allergies)

_____
_____

Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication? Yes o No o

Do you have any disease, condition or medical problem not listed you feel we should know about? Yes o No o

Today's Date

NOTES:

Please list all medications and dosages.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date: _____

Signature:

_____