Health History

Patient Name _____ Date _____

What is your dental problem? _____

Date of last dental treatment _____ Date of last full mouth X-rays _____

	Check One	
Are you having pain or discomfort at this time?	☐ Yes	☐ No
Do you feel very nervous about having dental treatment?	☐ Yes	☐ No
Have you ever had a bad experience in the dental office?	☐ Yes	☐ No
Have you ever taken any medicine or drugs during the past two years?	☐ Yes	☐ No
Are you now taking any medication, drugs, or pills?	☐ Yes	☐ No
If yes, please list: _____		
Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?	☐ Yes	☐ No
If yes, please list: _____		
Have you been a patient in the hospital during the past two years?	☐ Yes	☐ No
Have you been under the care of a medical doctor during the past two years?	☐ Yes	☐ No
Have you been taken Fen-Phen or Redux for weight loss?	☐ Yes	☐ No

Physician's Name _____

Address _____ Phone# _____

Indicate which of the following you have had or have at present. (check ***YES*** or ***NO*** to each item)

Heart Failure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No
Heart Disease or Attack	☐ Yes	☐ No	Cough	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Venereal Disease		
Artificial Heart Valve	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	(Syphilis, Gonorrhea)	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	X-ray or Cobalt Treatment	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Chemotherapy (Cancer, etc.)	☐ Yes	☐ No	Fever Blisters	☐ Yes	☐ No
Artificial Joints (Hip, Knee)	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Cosmetic Surgery	☐ Yes	☐ No	H.I.V. (A.I.D.S.)	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	☐ YES	☐ NO
Do your ankles swell during the day?	☐ YES	☐ NO
Do you use more than 2 pillows to sleep?	☐ YES	☐ NO
Have you lost or gained more than 10 pounds in the past year?	☐ YES	☐ NO
Do you ever wake up from sleep short of breath?	☐ YES	☐ NO
Are you on a special diet?	☐ YES	☐ NO
Has your medical doctor ever said you have a cancer or tumor?	☐ YES	☐ NO
Do you have any disease, condition, or problem not listed?	☐ YES	☐ NO

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO If yes, what month?_____ Are you taking birth control pills ☐ YES ☐ NO

UPDATE

Health Changes _____

Surgery _____

Current Medications _____

Address / Phone Change _____

Other information change

Initial _____ Date _____

Additional Updates

UPDATE

Health Changes _____

Surgery _____

Current Medications _____

Address / Phone Change _____

Other information change

Initial _____ Date _____

UPDATE

Health Changes _____

Surgery _____

Current Medications _____

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