



# Patient Health History

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

### GENERAL:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Is your general health good?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have there been any changes in your health within the last year?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you been hospitalized or had a serious illness in the last 3 years?
				If yes, why?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you being treated by a physician now?
				If yes, for what?
				Date of last medical exam? _____ Date of last dental exam? _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you had any problems with prior dental treatment?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you in pain now?

### HAVE YOU EXPERIENCED:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chest pain (angina)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Dizziness?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bleeding problems or bruising?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Headaches?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sinus problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fainting spells?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diarrhea or constipation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Seizures?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Frequent vomiting nausea?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Joint pain or stiffness?

### DO YOU HAVE OR HAVE YOU HAD:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart disease?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	AIDS/HIV?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart attack, heart defects?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tumors, cancer?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart murmurs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Arthritis, rheumatism?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatic fever?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Anemia?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stroke, hardening of arteries?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	VD (syphilis or gonorrhea) / Herpes?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High blood pressure?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney, bladder disease?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis A, B or C	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Asthma, TB, emphysema, other lung disease?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver disease?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid or adrenal disease?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Allergies to: drugs, food, medications, latex?

### DO YOU HAVE OR HAVE YOU HAD:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Psychiatric care?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Prosthetic heart valve?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Radiation treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Artificial joints? If yes:
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chemotherapy?					What antibiotics do you take before dental treatment?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pacemaker?					

### ARE YOU TAKING:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Recreational drugs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use tobacco in any form?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Drugs, medication or over-the-counter Medication including Aspirins or natural remedies?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use alcohol?

If YES please name: \_\_\_\_\_

### WOMEN ONLY:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you or could you be pregnant or nursing	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you taking birth control?
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### ALL PATIENT:

Do you have or have you had any other medical conditions NOT listed on this form?  
**If so, please explain:** \_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health history and update medications been used.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_