

# HEALTH HISTORY

Patient Name: \_\_\_\_\_ Patient Identification Number: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_

**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? |                          |       |  |
|    |     |    | If YES, why?   | _____                    |       |  |
| 4. | Yes | No | Are you being treated by a physician now? For what?                          | _____                    |       |  |
|    |     |    | Date of last medical exam?   | Date of last Dental exam | _____ |  |
| 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)?                     | 18. | Yes | No | Dizziness?             |
| 8.  | Yes | No | Swollen ankles?                          | 19. | Yes | No | Ringing in ears?       |
| 9.  | Yes | No | Shortness of breath?                     | 20. | Yes | No | Headaches?             |
| 10. | Yes | No | Recent weight loss, fever, night sweats? | 21. | Yes | No | Fainting spells?       |
| 11. | Yes | No | Persistent cough, coughing up blood?     | 22. | Yes | No | Blurred vision?        |
| 12. | Yes | No | Bleeding problems, bruising easily?      | 23. | Yes | No | Seizures?              |
| 13. | Yes | No | Sinus problems?                          | 24. | Yes | No | Excessive thirst?      |
| 14. | Yes | No | Difficulty swallowing?                   | 25. | Yes | No | Frequent urination?    |
| 15. | Yes | No | Diarrhea, constipation, blood in stools? | 26. | Yes | No | Dry mouth?             |
| 16. | Yes | No | Frequent vomiting, nausea?               | 27. | Yes | No | Jaundice?              |
| 17. | Yes | No | Difficulty urinating, blood in urine?    | 28. | Yes | No | Joint pain, stiffness? |

**III. DO YOU HAVE OR HAVE YOU HAD:**

- |     |     |    |   |     |     |    |                             |
|-----|-----|----|---|-----|-----|----|-----------------------------|
| 29. | Yes | No | Heart disease?                                      | 40. | Yes | No | AIDS                        |
| 30. | Yes | No | Heart attack, heart defects?                        | 41. | Yes | No | Tumors, cancer?             |
| 31. | Yes | No | Heart murmurs?                                      | 42. | Yes | No | Arthritis, rheumatism?      |
| 32. | Yes | No | Rheumatic fever?                                    | 43. | Yes | No | Eye diseases?               |
| 33. | Yes | No | Stroke, hardening of arteries?                      | 44. | Yes | No | Skin diseases?              |
| 34. | Yes | No | High blood pressure?                                | 45. | Yes | No | Anemia?                     |
| 35. | Yes | No | Asthma, TB, emphysema, other lung diseases?         | 46. | Yes | No | VD (syphilis or gonorrhea)? |
| 36. | Yes | No | Hepatitis, other liver disease?                     | 47. | Yes | No | Herpes?                     |
| 37. | Yes | No | Stomach problems, ulcers?                           | 48. | Yes | No | Kidney, bladder disease?    |
| 38. | Yes | No | Allergies to: drugs, foods, medications, latex?     | 49. | Yes | No | Thyroid, adrenal disease?   |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors? | 50. | Yes | No | Diabetes?                   |

**IV. DO YOU HAVE OR HAVE YOU HAD:**

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

**V. ARE YOU TAKING:**

- |     |     |    |   |     |     |    |                      |
|-----|-----|----|---|-----|-----|----|----------------------|
| 61. | Yes | No | Recreational drugs?   | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? | 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 you had any other diseases or medical problems 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 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: | _____ |