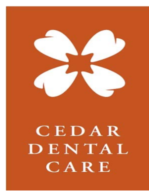

Confidential Health History

Patient Name: ______________________________ Date of Birth: ____________________

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

1. Is your general health good — YES NO. If NO, explain: ______________________
2. Has there been a change in your health within the last year? — YES NO. If YES, explain: ______________________
3. Have you gone to the hospital or emergency room or had serious illness in the last three years? — YES NO. If YES, explain: ______________________
4. Are you being treated by a physician now? — YES NO. If YES, explain: ______________________
   Date of last medical exam: __________ Reason for exam: ______________
5. Have you had problems with prior dental treatment? — YES NO. If YES, explain: ______________________
   Date of last dental exam: __________ Name of last treating dentist: ______________
6. Are you in pain now? — YES NO. If YES, explain: ______________________

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes	No	Chest pain (angina)	Yes	No	Blood in stools	Yes	No	Frequent vomiting
Yes	No	Fainting spells	Yes	No	Diarrhea or constipation	Yes	No	Jaundice
Yes	No	Recent significant weight loss	Yes	No	Frequent urination	Yes	No	Dry mouth
Yes	No	Fever	Yes	No	Difficulty urinating	Yes	No	Excessive thirst
Yes	No	Night sweats	Yes	No	Ringing in ears	Yes	No	Difficulty swallowing
Yes	No	Persistent cough	Yes	No	Headaches	Yes	No	Swollen ankles
Yes	No	Coughing up blood	Yes	No	Dizziness	Yes	No	Joint pain or stiffness
Yes	No	Bleeding problems	Yes	No	Blurred vision	Yes	No	Shortness of breath
Yes	No	Blood in urine	Yes	No	Bruise easily	Yes	No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes	No	Heart disease	Yes	No	AIDS/HIV	Yes	No	Psychiatric care
Yes	No	Family history of heart disease	Yes	No	Surgeries	Yes	No	Osteoporosis
Yes	No	Heart attack	Yes	No	Hospitalization	Yes	No	Thyroid disease
Yes	No	Artificial joint	Yes	No	Diabetes	Yes	No	Asthma
Yes	No	Stomach problems or ulcers	Yes	No	Family history of diabetes	Yes	No	Hepatitis
Yes	No	Heart defects	Yes	No	Tumors or cancer	Yes	No	Sexual transmitted disease
Yes	No	Heart murmurs	Yes	No	Chemotherapy	Yes	No	Herpes
Yes	No	Rheumatic fever	Yes	No	Radiation	Yes	No	Canker or cold sores
Yes	No	Skin disease	Yes	No	Arthritis, rheumatism	Yes	No	Tuberculosis
Yes	No	Hardening of arteries	Yes	No	Emphysema or other lung disease	Yes	No	Anemia
Yes	No	High blood pressure	Yes	No	Kidney or bladder disease	Yes	No	Liver disease
Yes	No	Seizures	Yes	No	Stroke	Yes	No	Eye disease
Yes	No	Cosmetic surgery	Yes	No	Eating disorders	Yes	No	Transplants

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes	No	Aspirin	Yes	No	Valium	Yes	No	Tetracycline
Yes	No	Darvon	Yes	No	Demerol	Yes	No	Vicodin
Yes	No	Codeine	Yes	No	Penicillin	Yes	No	Percodan
Yes	No	Latex	Yes	No	Food	Yes	No	Nitrous oxide
Yes	No	Local anesthetic (Novocain or Xylocaine)	Yes	No	Erythromycin	Yes	No	Metal

Others: ____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes	No	Recreational drugs	Yes	No	Tobacco in any form	Yes	No	Antibiotics
Yes	No	Over-the-counter medicines	Yes	No	Alcohol	Yes	No	Supplements
Yes	No	Weight loss medications	Yes	No	Bisphosphonate (Fosamax)	Yes	No	Aspirin

Please list all prescription medications: ______________________________

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes No Are you or could you be pregnant? If YES, what month? ______________________________

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:

____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why: ______________________________

Yes No Have you ever taken Fen-Phen? If YES, when: ______________________________

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________ Date: ______________________

Physician's Name: ______________________ Phone Number: ______________________

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient (Parent or Guardian) Date

____

Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS