

# PATIENT HEALTH HISTORY

Please answer each question. Circle **Yes** or **NO**

## MEDICAL HISTORY

1. Are you in good health?..... Yes No
2. Date of last physical examination? \_\_\_\_\_
3. Physician Name: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_
4. Are you now under the care of a physician? ..... Yes No  
If so, what is the condition being treated? \_\_\_\_\_
5. Have you ever had any serious illness or operation? ..... Yes No  
If so, what illness or operation? \_\_\_\_\_
6. Have you ever been hospitalized? ..... Yes No

- If so, what was the problem? \_\_\_\_\_
7. Are you taking any medicine? ..... Yes No  
If so, what? \_\_\_\_\_

- Or any recreational drugs (marijuana, cocaine, etc.)?..... Yes No
8. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
  9. Are you sensitive or allergic to any drugs? ..... Yes No  
 Penicillin  Tetracycline  Sulfa Drugs  Aspirin  Codeine  
 Other \_\_\_\_\_

10. Do you have or have you had any of the following: **Please check Yes or No (Y/N) for every condition.**

- |  |   |   |   |   |
|--|---|---|---|---|
| <b>Y / N</b>                           | <b>Y / N</b>                                      | <b>Y / N</b>                                | <b>Y / N</b>                                      | <b>Y / N</b>  |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Rheumatism               | <input type="checkbox"/> Sinus Trouble      | <input type="checkbox"/> Cortisone Medicine       | <input type="checkbox"/> X-Ray or Cobalt                            |
| <input type="checkbox"/> Hemophilia    | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Drug Addiction     | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Fainting Spells or Seizures                |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Failure            | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> HIV Positive             | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia)            |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Stomach Ulcers     | <input type="checkbox"/> Pain in Jaw Joints       | <input type="checkbox"/> Radiation Treatment of any kind            |
| <input type="checkbox"/> Herpes        | <input type="checkbox"/> Heart Ailments or Attack | <input type="checkbox"/> Angina Pectoris    | <input type="checkbox"/> Respiratory Disease      | <input type="checkbox"/> Hepatitis or Jaundice                      |
| <input type="checkbox"/> Ulcers        | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Mental Disorder    | <input type="checkbox"/> Sickle Cell Disease      | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)     |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Tuberculosis (T.B.)      | <input type="checkbox"/> AIDS (Acquired Immune Deficiency Syndrome) |
| <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Cardiac Pacemaker        | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> TMJ (Temporomandibular joint)              |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Bruise Easily            | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Artificial Prosthesis    | <input type="checkbox"/> Hearing Impaired                           |
| <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Head Injuries            | <input type="checkbox"/> Joint Replacement  | <input type="checkbox"/> Psychiatric Treatment    | <input type="checkbox"/> Latex or Metal Allergy                     |
| <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Nervous Disorders  | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Asthma                                     |
| <input type="checkbox"/> Tonsillitis   | <input type="checkbox"/> Scarlet Fever            | <input type="checkbox"/> Tumors or Growths  | <input type="checkbox"/> Difficulty in Swallowing | <input type="checkbox"/> Contact Lenses                             |
| <input type="checkbox"/> Cold Sores    | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Blood Transfusions       | <input type="checkbox"/> Other _____                                |

11. Do you have any disease, condition or problem not listed that you think I should know about?..... Yes No  
If so, what? \_\_\_\_\_
12. Have you ever taken Phen-Fen or other diet aids? ..... Yes No  
If so, what? \_\_\_\_\_

13. (Women) Is there a possibility you may be pregnant?..... Yes No
14. Do you smoke, or use any tobacco products? Yes No How much? \_\_\_\_\_
15. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
16. (Women) Do you take birth control pills? ..... Yes No

## DENTAL HISTORY

1. Previous Dentist \_\_\_\_\_  
City \_\_\_\_\_
2. How long since your last dental x-rays and treatment? \_\_\_\_\_
3. Have you had any serious trouble associated with any previous dental treatment?..... Yes No
4. Have you been having any specific problem? ..... Yes No  
Explain: \_\_\_\_\_
5. Does dental treatment make you nervous? ..... Yes No  
If so, check:  Slightly  Moderately  Severely

6. Do you have, or have you had any of the following: ..... Yes No  
(Please check known conditions)  Bad Breath  Loosening of Teeth  
 Headaches  Bleeding Gums  Sensitive Teeth  
 Jaws "Pop" or "Lock"  Sinus Trouble
7. Have you ever had any of the following? ..... Yes No  
 Injury  Oral Surgery  Orthodontics  Periodontics  
Explain: \_\_\_\_\_
8. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
9. Would you desire to be pre-sedated?..... Yes No  
 Nitrous Oxide  Drugs  Or \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

PATIENT, PARENT/GUARDIAN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DENTIST Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CHANGES IN HEALTH

DATE	NOTE CHANGES	PATIENT SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____