

HEALTH HISTORY

DATE: _____

PLEASE PRINT

Patient Name	Sex	Age	Birth Date	Home Phone	Business Phone
Responsible Party's Name		Soc. Sec. No.	Name of Insurance Plan/ID#		Insurance Phone Number
Patient Address			Patient City, State, Zip		
Patient Employer / Phone #		Spouse's Name		Spouse's Employer / Phone Number	
Name of Relative (not at same address)		Relative's Address / Phone #			
Physician's Name		Referring Dentist's Name		Orthodontist's Name	
Reasons for Visit Here			Family Members Who Have Been Patients Here		

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

ALL RESPONSES ARE KEPT CONFIDENTIAL

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| <p>1. Are you in good health?..... Y N</p> <p>2. Has there been <u>any</u> change in your general health in the past year?..... Y N</p> <p>3. Date of last physical exam?.....</p> <p>4. Are you now under a Physician's care for a particular problem?..... Y N</p> <p>5. Have you had any serious illnesses, operations, or hospitalizations? If so, please describe..... Y N</p> <p>6. Have you had any adverse effects from dental treatment?..... Y N</p> <p>7. Do you have or have you ever had:</p> <p style="margin-left: 20px;">A. Rheumatic fever or rheumatic heart disease?..... Y N</p> <p style="margin-left: 20px;">B. Congenital heart disease?..... Y N</p> <p style="margin-left: 20px;">C. Cardiovascular disease (heart trouble, heart attack, blood pressure, stroke, palpitations, heart surgery, pacemaker)?..... Y N</p> <p style="margin-left: 20px;">D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?..... Y N</p> <p style="margin-left: 20px;">E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown?..... Y N</p> <p style="margin-left: 20px;">F. Bleeding disorder, anemia, bleeding tendency, blood transfusions, do you bruise easily?..... Y N</p> <p style="margin-left: 20px;">G. Liver Disease (jaundice, hepatitis)?..... Y N</p> <p style="margin-left: 20px;">H. Kidney disease?..... Y N</p> <p style="margin-left: 20px;">I. Diabetes?..... Y N</p> <p style="margin-left: 20px;">J. Thyroid disease (goiter)?..... Y N</p> <p style="margin-left: 20px;">K. Arthritis?..... Y N</p> <p style="margin-left: 20px;">L. Stomach ulcers or colitis?..... Y N</p> <p style="margin-left: 20px;">M. Glaucoma?..... Y N</p> <p style="margin-left: 20px;">N. Frequent or recurring mouth sores?..... Y N</p> <p style="margin-left: 20px;">O. Implants placed anywhere in your body (heart valve hip, knee)?..... Y N</p> <p style="margin-left: 20px;">P. Radiation (X-ray,) treatment for cancer?..... Y N</p> <p style="margin-left: 20px;">Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..... Y N</p> <p style="margin-left: 20px;">R. Sinus or nasal problems?..... Y N</p> <p style="margin-left: 20px;">S. Any disease, drugs, or transplant operation that has depressed your immune system?..... Y N</p> <p style="margin-left: 20px;">T. Recurrent infections of any kind?..... Y N</p> <p>8. Are you using or taking any of the following:</p> <p style="margin-left: 20px;">A. Antibiotics?..... Y N</p> <p style="margin-left: 20px;">B. Anticoagulants (blood thinner, Coumadin, Plavix)?..... Y N</p> <p style="margin-left: 20px;">C. Aspirin, or other drugs such as Aleve, Ibuprofen?..... Y N</p> <p style="margin-left: 20px;">D. Asthma Medication?..... Y N</p> | <p>E. High blood pressure medication?..... Y N</p> <p>F. Heart medications (Digitalis, Inderal, Nitroglycerin, procordia)?..... Y N</p> <p>G. Diabetes medication (Insulin, oral antidiabetic drug)?..... Y N</p> <p>H. Thyroid medication?..... Y N</p> <p>I. Steroids?..... Y N</p> <p>J. Medicine for depression or anxiety?..... Y N</p> <p>K. Fosomax, Boniva, Actonel?..... Y N</p> <p>L. Aredia or Zometa?..... Y N</p> <p>9. Are you allergic or had bad reactions to:</p> <p style="margin-left: 20px;">A. Local anesthetic (Novocain, etc)?..... Y N</p> <p style="margin-left: 20px;">B. Penicillin, Amoxicillin, Cephalosporins, or other antibiotics?..... Y N</p> <p style="margin-left: 20px;">C. Barbiturates, Sedatives, etc.?..... Y N</p> <p style="margin-left: 20px;">D. Aspirin or Ibuprofen?..... Y N</p> <p style="margin-left: 20px;">E. Codeine or other pain killers?..... Y N</p> <p style="margin-left: 20px;">F. Latex or rubber products?..... Y N</p> <p style="margin-left: 20px;">G. Other allergies or reactions?..... Y N</p> <p style="margin-left: 40px;">If yes, please list: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">_____</p> <p>10. Do you smoke or chew tobacco?..... Y N</p> <p>11. Do you use alcohol?..... Y N</p> <p>12. Any history of alcohol or chemical dependency or emotional disorders that may affect the care we provide? Y N</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>13. FOR WOMEN ONLY</p> <p>A. If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your Physician for further guidance.</p> <p>B. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics, or any other medication may harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant!</p> <p>C. Do you wish to have a pregnancy test?..... Y N</p> </div> <p>14. Do you have any other disease, condition, or problem not listed that you think the Doctor should know about?..... Y N</p> <p>15. Do you wish to talk with the Doctor privately about anything?..... Y N</p> |
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I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

Signature of Person Completing Health History _____ Doctor's Signature _____ Date _____

MEDICAL UPDATE: I have read my health history dated _____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions or Changes _____ Patient's Signature _____ Doctor's Initials _____

COMMENTS: _____

