Confidential Health History

Patient Name _____Date of birth_____Date Filled out_____

Circle Appropriate Answer (Leave blank if you do not understand question)

1. Yes No Is your general health good?
   If NO, explain_____
2. Yes No Has there been a change in your health within the last year?
   If yes, explain_____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?_____
4. Yes No Are you being treated by a physician now? If yes, explain_____
   Date of last medical exam_____ Reason for exam_____
5. Yes NO Have you had problems with prior dental treatment?
   If yes, explain_____Name of last treating dentist_____
6. Yes No Are you in pain now? Have you had any recent trauma to mouth or teeth?
   If yes, explain_____
7. Yes No Do you engage in physical sports , and if yes, what kind_____

Have you experienced any of the following? Circle Yes or NO

Chest Pain	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 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	Yes No

Have you had or do you have any of the following? Circle Yes or No

Heart disease	Yes No	AIDS/HIV	Yes No	Family history of heart disease	Yes No
Surgeries	Yes No	Osteoporosis	Yes No	Depression/Anxiety Disorder	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	Sexually 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	Anemia	Yes No
Hardening of arteries	Yes No	Emphysema or lung disease	Yes No	Liver disease	Yes No
High blood pressure	Yes No	Kidney or bladder disease	Yes No	Eye disease	Yes No
Seizures	Yes No	Stroke	Yes No	Transplants	Yes No
Cosmetic surgery	Yes No	Eating disorders	Yes No	Tuberculosis	Yes No

Are you allergic or have you had a reaction to any of the following? Circle Yes or 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
Local Anesthetic(Lidocaine)	Yes No	Latex	Yes No	Foods	Yes No
Nitrous Oxide	Yes No	Erthromycin	Yes No	Metals	Yes No

Others:

_____

_____

Are you taking or have you taken any of the following in the last 3 months?

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

Please list daily medications: _____

_____

_____

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 other issue or condition you would like to discuss with the dentist In private?

Women only (Please Circle)

Yes No Are you or could be pregnant?
If yes, what month?_____

Yes No Are you nursing?

Yes No Are you taking birth control?

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.

Patient's/Parent Signature _____ **Date**_____

Medical Physician's Name _____ **MD 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 have made in the completion of this form.

_____ _____ _____ _____

Signature of patient or (parent or guardian) **Date** **Signature of Dentist** **Date**

Medical Updates

Date	Patient signature	Changes in Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____