

**HEALTH HISTORY**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone # \_\_\_\_\_

Physicians Address \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**MEDICAL**

- 1. Are you in good health? \_\_\_\_\_  YES  NO
  - 2. Has there been any change in your general health within the past year? \_\_\_\_\_  YES  NO
  - 3. Date of last physical examination? \_\_\_\_\_
  - 4. Are you now under the care of a physician? \_\_\_\_\_  YES  NO  
If so what condidtion? \_\_\_\_\_
  - 5. Have you ever had any serious illness, operation, or hospitalization? \_\_\_\_\_  YES  NO
  - 6. Are you taking any drugs or medication? \_\_\_\_\_  YES  NO
  - 7. List type amount and frequency if so \_\_\_\_\_
  - 8. Are you using any recreational drugs? \_\_\_\_\_  YES  NO
  - 9. Are you taking any over the counter drugs? \_\_\_\_\_  YES  NO
  - 10. Are you sensitive or allergic to any medication? \_\_\_\_\_  YES  NO  
 Penicillin  Sulfa  Codeine/other Narcotic  Aspirin  Barbiturates  Iodine  other \_\_\_\_\_
  - 11. Do you have or have you had any of the following: (Please check known conditions)
- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Aids or HIV         | <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Blood Diseases _____      | <input type="checkbox"/> Head Injuries                        | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Sinus Trouble             | <input type="checkbox"/> Stomach Ulcers                       | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Heart Ailments      | <input type="checkbox"/> Sickle Cell Anemia        | <input type="checkbox"/> Venereal Disease                     | <input type="checkbox"/> Heart Murmur        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Mental Disorders                     | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Tumors/Growths      | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> Radiation treatment                  | <input type="checkbox"/> Asthma/Hay Fever    |
| <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Allergies _____           | <input type="checkbox"/> Glaucoma                             | <input type="checkbox"/> None of the above   |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Fainting Spells/ Seizures | <input type="checkbox"/> Hepatitis, Jaundice or liver disease |  |
|  |  | <input type="checkbox"/> Other _____                          |  |

If you checked yes to any of the above conditions, please give a brief explanation:

\_\_\_\_\_

- 12. Do you use tobacco now or in the past? \_\_\_\_\_  YES  NO
- 13. Do you wear a cardiac pacemaker? \_\_\_\_\_  YES  NO
- 14. Have you had Heart surgery? \_\_\_\_\_  YES  NO
- 15. Do you have any disease or condition or problem not list above that you think I should know about?  YES  NO  
If yes, what is it? \_\_\_\_\_
- 16. If you are Women, are you pregnant or nursing? If so, how many months? \_\_\_\_\_

**DENTAL**

- 1. Previous Dentist \_\_\_\_\_
  - 2. Was your pattern of visits  regular  infrequent  sporadic
  - 3. Have you been having any specific problems? \_\_\_\_\_  YES  NO  
Explain \_\_\_\_\_
  - 4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment? \_\_\_\_\_  YES  NO
  - 5. Does dental treatment make you nervous? \_\_\_\_\_  YES  NO
  - 6. Do you have or have not had any of the following: (Please check known conditions)
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Loosening of teeth   | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Cold sores                   | <input type="checkbox"/> Clench your teeth  |  |
| <input type="checkbox"/> Sensitive Teeth at . . . . . | <input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Sweet <input type="checkbox"/> Temperature   |  |
| <input type="checkbox"/> Grind your teeth at. . . . . | <input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Hurt <input type="checkbox"/> Lock <input type="checkbox"/> Jaw <input type="checkbox"/> Pop |  |
- 7. Have you ever had any serious trouble associated with any previous dental treatment? \_\_\_\_\_  YES  NO
  - 8. Have you ever had any of the following:  
 Injury  Oral Surgery  Orthodontics  Periodontics
  - 9. Do you like the overall appearance of your teeth? \_\_\_\_\_  YES  NO

\_\_\_\_\_  
Patient/Guardian Signature Date Doctor Signature

\_\_\_\_\_  
Recall Pateint Signature Date Doctor Signature

\_\_\_\_\_  
Recall Patient Signature Date Doctor Signature