HEALTH HISTORY

Patient Name:_____ Tel: Wk_____ Hm_____ Cl_____

Birth Date:_____

I.CIRCLE APPROPRIATE ANSWER: (leave Blank if you do not understand question)

1. Yes No Is your general health good?
2. Yes No Has there been a change in you health within the last year?
3. Yes No have you been hospitalized or had a serious illness in the last three years
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam?_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen Ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily, Hemophilia?	23.	Yes	No	Seizures, Epilepsy?
13.	Yes	No	Sinus Problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS, HIV ?
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, Rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye disease, glaucoma?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure, Low blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung disease?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Family history of diabetes, heart problems, tumors?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Allergies to: drugs, food, medications, latex?	50.	Yes	No	Diabetes?
			Please list:_____	51.	Yes	No	Shingles?
				52.	Yes	No	Sickle Cell?

IV. DO YOU HAVE OR HAVE YOU HAD:

53.	Yes	No	Psychiatric care?	58.	Yes	No	Hospitalizations?
54.	Yes	No	Radiation treatments?	59.	Yes	No	Blood transfusions?
55.	Yes	No	Chemotherapy?	60.	Yes	No	Surgeries?
56.	Yes	No	Prosthetic heart valve?	61.	Yes	No	Pacemaker?
57.	Yes	No	Artificial joint?	62.	Yes	No	Contact Lenses?

V. ARE YOU TAKING:

63.	Yes	No	Recreational drugs?	66.	Yes	No	Tobacco in any form?
64.	Yes	No	Fen PHEN, Phosmax?	67.	Yes	No	Alcohol?
65.	Yes	No	Drugs, medications, over-the-counter medicines (including Asprin), natural remedies				

Please list:_____
_____

VI. WOMEN ONLY:

68.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

69. Yes No Do you have or have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____
_____

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

Patient's signature:_____Date:_____

A minimum $75.00 charge will be made for all failed or cancelled appointments without 48 hour notification.

Patient's Signature:_____Date:_____