Health History

Patient name: ______________________________ Age: ______ Sex: M / F

Home address: ______________________________ Cell #: (___) ____________

In case of emergency, contact ______________________________ Phone # :(___) ____________

Why are you here today? ______________________________

When was your last visit to a dental office? ____________________ Who is your Dentist? ____________________

#	Question	Y	N
1.	Do you have any medical/health problems?		
2.	Has there been any change in your general health in the past year?		
3.	My last physical was on ____________________		
4.	Are you currently under the care of a physician?		
5.	If so what is the condition being treated? ____________________		
6.	The name and address of my physician is ____________________ ____________________		
7.	Have you had any serious illness or operation?		
8.	If so what was the illness or opertaion? ____________________		
9.	Have you been hospitalized or had a serious illness within the past five (5) years?		
10.	If so what was the problem? ____________________		
11.	Do you have any of the following diseases or problems?		
a.	Damaged heart valves or artificial heart valves?		
b.	Congenital heart lesions or murmurs?		
c.	Cardiovascular disease? (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)		
d.	Do you have chest pain upon exertion?		
e.	Are you ever short of breath after mild exercise?		
f.	Do your ankles swell?		
g.	Do you get short of breath when you lay down?		
h.	or do you require extra pillows when you sleep?		
i.	Do you have a cardiac pacemaker?		
j.	Have you ever been required to be pre-medicated with Antibiotics prior to your dental visit?		
k.	Cancer/ Chemotherapy?		
l.	Drug/ alcohol use?		
m.	Psychiatric/ emotional therapy?		
n.	Rheumatic fever?		
o.	Sinus trouble?		
p.	Asthma?		
q.	Allergies?		
r.	Hives or skin rash?		
s.	Fainting spells or seizures?		
t.	Tuberculosis?		
u.	Diabetes?		
	• -Do you urinate more than six (6) times a day?		
	• -Are you thirsty much of the time?		
	• -Does your mouth frequently become dry?		
v.	Hepatitis, jaundice or liver disease?		
w.	Arthritis?		
x.	Inflammatory rheumatism (painful, swollen joints)?		
y.	Stomach ulcers?		
z.	Kidney trouble?		
aa.	Do you have a persistent cough or cough up blood?		
bb.	Low blood pressure?		
cc.	Venereal disease? (AIDS, HIV,...)		
dd.	Do you have a prosthetic: joint prosthesis ____, implants ____, bone plates ____, or screws ____, other ____________ hip ____,		
12.	Have you had abnormal bleeding, associated with previous extractions, surgery, or trauma?		
a.	Do you bruise easily?		
b.	Have you ever required a blood transfusion?		

Y N

c. Do you have any blood disorder such as anemia?........................
13. Have you had surgery or x-ray treatment for a tumor growth, or other condition of your mouth or lips?......................
14. Are you taking any of the following medications?.......................
a. Antibiotics or sulfa drugs: ______________________
b. Anticoagulants (blood thinners): ________________
c. Medicine for high blood pressure: ________________
d. Cortisone (steroids): ________________________
e. Tranquilizers ____, Antihistamine ____, Aspirin ____
f. Insulin, tolbutamide (orinase) or similar drug: ______________________________
g. Digital or drugs for heart trouble: ________________
h. Nitroglycerine?..
i. Are you allergic or have you reacted adversely to any of the following:.. metal ____, Dental anesthetics ____, Penicillin or other antibiotics ____, Sulfa drugs ____, Barbiturates, sedatives or sleeping pills ____, Aspirin ____, Lodine ____, Codeine or other narcotics ____,
j. Are you allergic to rubber or latex products?............................
k. other: ____________________________
l. Have you ever taken diet medication Redux (Fen-Phen)?............
15. Have you ever undergone oral or IV Bis-Phosphonate Therapy (Actonel, Fosamax, Aredia, Zometa, etc)?......................
16. Do you have any disease, condition or problem not listed above that you think we should know about? ....
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?..........................
18. Do you wear contact lenses?...

Y N

19. Have you ever had any of the following conditions: .... Herpes ____, Hepatitis ____, Tuberculosis ____, HIV/AIDS ____.
20. Do you have any problems associated with your menstrual period?..
21. Are you nursing?...
22. Are you pregnant?...
23. Have you had any serious trouble associated with any previous dental treatment?............................... How often do you brush your teeth? ____ When? ____________________________________
24. How often do you use dental floss? ________________
25. Do your gums bleed or hurt? ....
a. How often? __________________
26. Are your teeth sensitive to: Hot ____, Cold ____, Sweets ____, Pressure ____?
27. Does food get caught in your teeth?
28. Do you have frequent headaches?...................................... neck aches ____or shoulder aches ____?.........................
29. Have you experienced any pain or soreness in the muscle of your face or around your ear?............................
30. Does your jaw pop or click? (TMJ)
31. Do you have or have you had any of the following problems: injuries to the face, ____ Gum problems ____ Injuries the teeth ____, ,Extra teeth ____, Missing teeth ____ Difficulty chewing ____, Speech problems ____?
32. Do you have or have you had any of the following habits: Grinding teeth ____, Tongue thrusting ____, Chewing gum ____Pen, lip or nail biting ____ Thumb or finger sucking ____ ....

Follow up to Medical History by Doctor only:

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I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and necessary treatments.

Signature of PATIENT or the Guardian if patient is a minor X ______________________________________ Date ____________

Name/ Signature of Doctor X ______________________________ office location: __________________ Date: __________________