Health History

Patient Name: _____ Birth Date: _____

CHECK ALL BOXES AS APPROPRIATE:

- ☐ YES ☐ NO Is your general health good?
- ☐ YES ☐ NO Has there been a change in your health within the last year?
- ☐ YES ☐ NO Have you been hospitalized or had a serious illness in the last 3 years? If yes, why? _____
- ☐ YES ☐ NO Are you being treated by a physician now?
- ☐ YES ☐ NO Are you in pain?

Date of last medical exam _____ Date of last dental exam _____

Name of current physician/PCP: _____ Phone number of physician/PCP: _____

Name of current dentist: _____ Phone number of dentist: _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING WITHIN THE PAST 6 MONTHS:

☐ YES	☐ NO	Chest pain (angina)	☐ YES	☐ NO	Dizziness
☐ YES	☐ NO	Swollen ankles	☐ YES	☐ NO	Ringing in ears
☐ YES	☐ NO	Shortness of breath	☐ YES	☐ NO	Headaches
☐ YES	☐ NO	Recent weight loss	☐ YES	☐ NO	Fainting spells
☐ YES	☐ NO	Persistent cough, or coughing up blood	☐ YES	☐ NO	Blurred vision
☐ YES	☐ NO	Bleeding problem	☐ YES	☐ NO	Seizures
☐ YES	☐ NO	Bruise easily	☐ YES	☐ NO	Excessive thirst
☐ YES	☐ NO	Sinus problems	☐ YES	☐ NO	Frequent urination
☐ YES	☐ NO	Difficulty swallowing	☐ YES	☐ NO	Dry mouth
☐ YES	☐ NO	Diarrhea, constipation, or blood in stools	☐ YES	☐ NO	Jaundice
☐ YES	☐ NO	Frequent vomiting or nausea	☐ YES	☐ NO	Joint paint, stiffness
☐ YES	☐ NO	Difficulty urinating, or blood in urine	☐ YES	☐ NO	Fever

DO YOU HAVE OR HAVE YOU HAD:

☐ YES	☐ NO	Heart disease	☐ YES	☐ NO	AIDS
☐ YES	☐ NO	Heart attack or heart defects	☐ YES	☐ NO	Tumors, cancer
☐ YES	☐ NO	Heart murmurs	☐ YES	☐ NO	Arthritis, rheumatism
☐ YES	☐ NO	Rheumatic fever	☐ YES	☐ NO	Eye disease(s)
☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Skin disease(s)
☐ YES	☐ NO	High blood pressure	☐ YES	☐ NO	Anemia
☐ YES	☐ NO	Asthma, TB or emphysema	☐ YES	☐ NO	Syphilis or gonorrhea
☐ YES	☐ NO	Allergies to foods, medications, drugs or latex	☐ YES	☐ NO	Herpes
☐ YES	☐ NO	Family history of diabetes or heart problems	☐ YES	☐ NO	Kidney, bladder disease
☐ YES	☐ NO	Thyroid, adrenal disease	☐ YES	☐ NO	Diabetes

DO YOU HAVE, OR HAVE YOU HAD:

☐ YES	☐ NO	Psychiatric care	☐ YES	☐ NO	Hospitalization
☐ YES	☐ NO	Radiation treatments	☐ YES	☐ NO	Blood transfusions
☐ YES	☐ NO	Chemotherapy	☐ YES	☐ NO	Surgeries: Type and date_____
☐ YES	☐ NO	Prosthetic heart valve	☐ YES	☐ NO	Pacemaker
☐ YES	☐ NO	Artificial joint	☐ YES	☐ NO	Seizures

ARE YOU TAKING:

☐ YES	☐ NO	Recreational drugs	☐ YES	☐ NO	Tobacco in any form
☐ YES	☐ NO	Drugs, medications, OTC medicines	☐ YES	☐ NO	Alcohol

Please list:___ _____

_____

WOMEN ONLY:

☐ YES ☐ NO Are you or could you be pregnant or nursing? ☐ YES ☐ NO Are you on any form of birth control?

ALL PATIENTS:

☐ YES ☐ NO Do you have or have you had any other diseases or medical conditions NOT listed?

If so, please explain: _____

☐ YES ☐ NO Do you have any known allergies to food, drugs, latex, or medicines?

If so, please list all allergies: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dental hygienist of any change in my health and/or medication.

Patient's signature: _____ Date _____

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