Confidential Health History Form (Page 1 of 2)

Today's Date:________________

Patient Name: ____ **Date of Birth:**________________
First MI Last

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No Is your general health good?
   If NO, explain____
2. Yes / No Are you being treated by a physician now?
   If YES, explain____
   Date of last medical exam___________Reason for exam______________________________
3. Yes / No Have you had problems with prior dental treatment?
   If YES, explain____
   Date of last dental exam____________Name of last treating dentist______________________
4. Yes / No Have you ever been pre-medicated for dental treatment?
   If YES, why____
5. Yes / No Are you in pain now?
   If YES, explain____

II. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	AIDS/HIV	Yes / No	Excessive Thirst	Yes / No	Lung Disease
Yes / No	Alzheimer's Disease	Yes / No	Fainting Spells/Dizziness	Yes / No	Mitral Valve Prolapse
Yes / No	Anaphylaxis	Yes / No	Frequent Cough	Yes / No	Osteoporosis
Yes / No	Anemia	Yes / No	Frequent Diarrhea	Yes / No	Pain in Jaw Joints
Yes / No	Angina	Yes / No	Frequent Headaches	Yes / No	Parathyroid Disease
Yes / No	Arthritis/Gout	Yes / No	Genital Herpes	Yes / No	Psychiatric Care
Yes / No	Artificial Heart Valve	Yes / No	Glaucoma	Yes / No	Radiation Treatment
Yes / No	Artificial Joint / Hip	Yes / No	Hay Fever	Yes / No	Recent Weight Loss
Yes / No	Asthma	Yes / No	Heart Attack/Failure	Yes / No	Renal Dialysis
Yes / No	Blood Disease	Yes / No	Heart Murmur	Yes / No	Rheumatic Fever
Yes / No	Blood Transfusion	Yes / No	Heart Pace Maker	Yes / No	Rheumatism
Yes / No	Breathing Problems	Yes / No	Heart Disease	Yes / No	Scarlet Fever
Yes / No	Bruise Easily	Yes / No	Hemophilia	Yes / No	Shingles
Yes / No	Cancer	Yes / No	Hepatitis A	Yes / No	Sickle Cell Disease
Yes / No	Chemotherapy	Yes / No	Hepatitis B	Yes / No	Sinus Trouble
Yes / No	Chest Pains	Yes / No	Hepatitis C	Yes / No	Spina Bifida
Yes / No	Cold Sores	Yes / No	Herpes	Yes / No	Stomach/Intestinal Disease
Yes / No	Congenital Heart Disorder	Yes / No	High Blood Pressure	Yes / No	Stroke
Yes / No	Convulsions	Yes / No	High Cholesterol	Yes / No	Swelling of Limbs
Yes / No	Cortisone Medicine	Yes / No	Hives or Rash	Yes / No	Thyroid Disease
Yes / No	Diabetes	Yes / No	Hypoglycemia	Yes / No	Tonsillitis
Yes / No	Drug Addiction	Yes / No	Irregular Heart Beat	Yes / No	Tuberculosis
Yes / No	Easily Winded	Yes / No	Kidney Problems	Yes / No	Tumors or Growths
Yes / No	Emphysema	Yes / No	Leukemia	Yes / No	Ulcers
Yes / No	Epilepsy or Seizures	Yes / No	Liver Disease	Yes / No	Venereal Disease
Yes / No	Excessive Bleeding	Yes / No	Low Blood Pressure	Yes / No	Yellow Jaundice

III. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Iodine	Yes / No	Penicillin
Yes / No	Codeine	Yes / No	Latex	Yes / No	Sulfa Drugs

Others____

 Today's Date:________________

IV. Please list all medications you are currently taking (please provide MED LIST if available):

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

V. All patients *(Please circle Yes or No for each)*

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, ____

Yes / No Have you ever been hospitalized or had a major operation?
If YES, ____

Yes / No Have you ever had a serious head or neck injury?
If YES, ____

Yes / No Have you ever taken Fen-Phen or Redux?
If YES,____

Yes / No Have you ever taken bisphosphonate medications (Fosamax, Boniva, Actonel, Zometa, etc.)?
If YES, ____

Yes / No Are you on a special diet?
If YES, ____

Yes / No Do you use tobacco?
If YES, ____

Yes / No Do you have a history of Alcoholism or drug addiction?
If YES, ____

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

VI. Women only *(Please circle Yes or No for each)*

Yes / No Are you or could you be pregnant? If YES, how many weeks?______________________

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

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 changes 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 may have made in the completion of this form.

Signature of Patient (Parent or Guardian) ______________________________Date ______________

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. ***Thank you*** *for taking the time to answer the above questions.*

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