



### Health History

Patient's name \_\_\_\_\_ DOB \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex M F

**For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.**

1. Are you in good health?  
 .....Yes No
2. Has there been any change in your health since last year? .....Yes No
3. My last physical exam was on \_\_\_\_\_
4. Are you under the care of a physician? .....Yes No  
 If yes, for what condition? \_\_\_\_\_
5. Name of primary care physician \_\_\_\_\_ PCP phone # \_\_\_\_\_
6. Have you had any serious illness, operation, or hospitalization within the last 5 years? .....Yes No
7. Have you had any adverse reactions from dental treatment? .....Yes No
8. Are you taking any medicine(s) including non-prescription? ..... Yes No  
 If yes, please list: \_\_\_\_\_
9. Do you have or have you had any of the following diseases or problems?
  - a. Damaged heart valves, artificial valves or murmur? .....Yes No
  - b. Rheumatic fever or rheumatic heart disease? ..... Yes No
  - c. Congenital heart condition, heart attack, angina, high blood pressure, stroke, arteriosclerosis, pacemaker, or any other heart condition? ..... Yes No  
 Chest pain on exertion, shortness of breath after mild exercise? ..... Yes No  
 Do your ankles swell?  
 ..... Yes No
  - d. Allergies, sinus or nasal trouble, ASTHMA, or hay fever? .....Yes No
  - e. Seizures, convulsions, epilepsy, fainting spells, or treatment for dizziness? ..... Yes No
  - f. Diabetes? ..... Yes No
  - g. Hepatitis, jaundice, or liver disease?  
 ..... Yes No
  - h. Frequent or recurring mouth sores?  
 ..... Yes No

- i. Thyroid problems? ..... Yes No
- j. Lung disease or respiratory problems, asthma, emphysema, bronchitis, COPD, pneumonia, tuberculosis, or severe coughing ..... Yes No
- k. Arthritis or painful, swollen joints? ..... Yes No
- l. Stomach ulcers, hyperacidity, or colitis? ..... Yes No
- m. Kidney disease or trouble? ..... Yes No
- n. Low blood pressure? ..... Yes No
- o. Cancer or any treatment for a tumor or growth? ..... Yes No
- p. Implants placed anywhere on your body (heart valve, hip, knee, etc.)? ..... Yes No
- q. Recurrent infections, persistent swollen neck glands? ..... Yes No
- r. Problems with mental health or treatment for psychiatric disorder? ..... Yes No
- s. Any disease drugs or transplant operation that has depressed your immune system? ..... Yes No
- t. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Yes No
- 10. Have you had abnormal bleeding, anemia, and bleeding disorder or required a blood transfusion? ..... Yes No
- 11. Are you allergic or have you had a reaction to:
  - a. Local anesthetics (novocaine, etc.)? ..... Yes No
  - b. Penicillin, amoxicillin, cephalosporins, or other antibiotics? ..... Yes No
  - c. Sulfur drugs? ..... Yes No
  - d. Barbiturates, sedatives, sleeping pills, etc.? ..... Yes No
  - e. Aspirin or ibuprofen? ..... Yes No
  - f. Codeine, narcotics or other painkillers? ..... Yes No
  - g. Other allergies or reactions? ..... Yes No
- 12. Do you have any other condition or disease you think I should know about? ..... Yes No

If yes, please explain \_\_\_\_\_

13. Do you smoke or chew tobacco?..... Yes No

14. Do you use alcohol?..... Yes No

15. For woman only

a. Are you pregnant?..... Yes No

b. Are you nursing?..... Yes No

c. Are you taking birth control pills?..... Yes No

\*If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one month after course of antibiotics or other medications are completed. Please contact your physician for further guidance.

\*If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or other medications may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is a possibility of your being pregnant.

Chief dental complaint:

\_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of patient, parent (if child) or guardian      Date

\_\_\_\_\_  
Doctor's signature      Date