PRAIRIE STAR Health Center

HEALTH HISTORY

Patient Name: _____ **Patient Date of Birth:** _____

CIRCLE APPROPRIATE ANSWER:

1. ☐Yes No☐ Is your general health good?
2. ☐Yes No☐ Has there been a change in your health within the last year?
3. ☐Yes No☐ Have you been hospitalized or had a serious illness in the last 3 years?
   If yes, why?_____
4. ☐Yes No☐ Are you being treated by a physician now? For what?_____
   Name of Primary Care Dr. _____Date of last dental exam_____
5. ☐Yes No☐ Have you had problems with prior dental treatment?
6. ☐Yes No☐ Are you in pain now?

HAVE YOU EXPERIENCED:

7. ☐Yes No☐ Chest pain (angina)
8. ☐Yes No☐ Shortness of Breath
9. ☐Yes No☐ Recent weight loss, fever, night sweats
10. ☐Yes No☐ Persistent cough, coughing up blood
11. ☐Yes No☐ Bleeding problems, bruising easily
12. ☐Yes No☐ Sinus problems
13. ☐Yes No☐ Difficulty swallowing
14. ☐Yes No☐ Diarrhea, constipation, blood in stools
15. ☐Yes No☐ Frequent vomiting, nausea
16. ☐Yes No☐ Difficulty urinating, blood in urine
17. ☐Yes No☐ Dizziness, Fainting spells
18. ☐Yes No☐ Ringing in ears, Blurred Vision
19. ☐Yes No☐ Headache
20. ☐Yes No☐ Seizures, Epilepsy
21. ☐Yes No☐ Excessive thirst
22. ☐Yes No☐ Dry mouth
23. ☐Yes No☐ Jaundice
24. ☐Yes No☐ Joint pain

DO YOU HAVE OR HAVE HAD:

25. ☐Yes No☐ Heart Disease
26. ☐Yes No☐ Heart attack, heart defect
27. ☐Yes No☐ Heart murmurs
28. ☐Yes No☐ Rheumatic fever
29. ☐Yes No☐ Stroke, hardening of arteries
30. ☐Yes No☐ High blood pressure
31. ☐Yes No☐ Asthma, TB, emphysema, other lung disease
32. ☐Yes No☐ Stomach problems, ulcers
33. ☐Yes No☐ Allergies to: drugs, foods, medications, latex
34. ☐Yes No☐ Family history of diabetes, heart problems, tumors
35. ☐Yes No☐ Hepatitis
36. ☐Yes No☐ AIDS/HIV
37. ☐Yes No☐ Tumors, cancers
38. ☐Yes No☐ Arthritis, rheumatism
39. ☐Yes No☐ Eye Disease
40. ☐Yes No☐ Skin diseases
41. ☐Yes No☐ Anemia
42. ☐Yes No☐ VD (syphilis or gonorrhea)
43. ☐Yes No☐ Herpes
44. ☐Yes No☐ Kidney, bladder disease
45. ☐Yes No☐ Thyroid, adrenal glands
46. ☐Yes No☐ Diabetes

DO YOU HAVE OR HAD:

47. ☐Yes No☐ Psychiatric care
48. ☐Yes No☐ Radiations treatments
48. ☐Yes No☐ Chemotherapy
50. ☐Yes No☐ Prosthetic heart valve/congenital heart defect
51. ☐Yes No☐ Artificial Joint
52. ☐Yes No☐ Hospitalization
53. ☐Yes No☐ Blood transfusion
54. ☐Yes No☐ Surgeries
55. ☐Yes No☐ Pacemaker
56. ☐Yes No☐ Contact lenses

ARE YOU TAKING:

57. ☐Yes No☐ Recreational drugs
58. ☐Yes No☐ Drugs, medication, over-the counter medications (including aspirin), natural remedies
59. ☐Yes No☐ Bisphosphonates
60. ☐Yes No☐ Tobacco in any form
61. ☐Yes No☐ Alcohol

Please List _____
_____

WOMEN Only:

62. ☐Yes No☐ Are you or could you be pregnant or nursing?
63. ☐Yes No☐ Taking birth control pills

ALL PATIENTS:

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

If so, please explain_____
_____

Patient
Signature:_____Date:_____