

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

**DO YOU HAVE OR HAVE HAD:**

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

**DO YOU HAVE OR HAD:**

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

**ARE YOU TAKING:**

- |   |                                |
|---|--------------------------------|
| 57. Yes No Recreational drugs   | 59. Yes No Bisphosphonates     |
| 58. Yes No Drugs, medication, over-the counter medications<br>(including aspirin), natural remedies | 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: \_\_\_\_\_