Dental Patient Health History Form

PRAIRIE STAR Health Center

LAST NAME	FIRST	DATE OF BIRTH	AGE
ADDRESS		DATE OF LAST DENTAL EXAM	
ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO		IF YES, FOR WHAT?	
NAME OF PRIMARY CARE PROVIDER		**PREFERRED PHARMACY**	
SPECIALIST(S) YOU ARE CURRENTLY SEEING			

GENERAL HEALTH

IS YOUR GENERAL HEALTH GOOD? ☐ YES ☐ NO		
HAS THERE BEEN A CHANGE IN YOUR OVERALL HEALTH WITHIN THE LAST YEAR? ☐ YES ☐ NO		
HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 3 YEARS? ☐ YES ☐ NO		
IF YES, PLEASE EXPLAIN	DATE OF HOSPITALIZATION	
HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT? ☐ YES ☐ NO		
ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO		
DO YOU FEEL NERVOUS OR ANXIOUS WHEN GOING TO THE DENTIST? ☐ YES ☐ NO		

PAST AND PRESENT MEDICAL PROBLEMS (PLEASE CHECK AND DESCRIBE)

CARDIOVASCULAR	EYES, EARS, NOSE & MOUTH	ENDOCRINE
☐ HIGH BLOOD PRESSURE	☐ EYE DISEASE	☐ THYROID DISEASE: ☐ HYPO ☐ HYPER
☐ HEART ATTACK	☐ SINUS PROBLEMS	☐ DIABETES
☐ CHEST PAIN	**GASTROINTESTINAL**	☐ EXCESSIVE THIRST
☐ HEART DISEASE	☐ FREQUENT NAUSEA/ VOMITING	☐ DRY MOUTH
☐ HEART MURMURS	☐ GASTROESOPHOGEAL REFLUX DISEASE	☐ DIFFICULTY SWALLOWING
☐ PROSTHETIC HEART VALVE	☐ STOMACH PROBLEMS	**RHEUMATOLOGY**
☐ CONGENITAL HEART DEFECT	☐ ULCERS	☐ ARTHRITIS / RHEUMATISM
☐ PACEMAKER	☐ LIVER DISEASE	☐ RHEUMATIC FEVER
GENERAL	☐ HEPATITIS: ☐ A ☐ B ☐ C	☐ INFECTIVE ENDOCARDITIS
☐ FEVER	**INFECTIOUS DISEASE**	☐ ARTIFICIAL JOINT
☐ NIGHT SWEATS	☐ AIDS / HIV	**HEMATOLOGY**
☐ WEIGHT GAIN	☐ HERPES	☐ BLEEDING PROBLEMS
☐ WEIGHT LOSS	☐ VD (syphilis or gonorrhea)	☐ EASY BRUISING
URINARY	☐ SKIN DISEASE	☐ BLOOD TRANSFUSION
☐ KIDNEY DISEASE	**PSYCHOLOGICAL**	☐ ANEMIA
☐ BLADDER DISEASE	☐ ANXIETY	**ONCOLOGY**
PULMONARY	☐ DEPRESSION	☐ CANCER
☐ ASTHMA	**NEUROLOGICAL**	☐ TUMORS
☐ COPD / EMPHYSEMA	☐ DIZZINESS	☐ CHEMOTHERAPY
☐ SHORTNESS OF BREATH	☐ FAINTING SPELLS	☐ RADIATION TREATMENTS
☐ TUBERCULOSIS	☐ SEIZURES / EPILEPSY	**ALLERGIES**
WOMEN ONLY	☐ HEADACHE	☐ FOOD
☐ PREGNANT OR NURSING	☐ MIGRAINE	☐ MEDICATIONS
☐ TAKING BIRTH CONTROL PILLS	☐ STROKE/HARDENING OF ARTERIES	☐ LATEX

FAMILY HISTORY OF:

☐ DIABETES	☐ HEART PROBLEMS	☐ TUMORS

SOCIAL HISTORY

☐ RECREATIONAL DRUGS	☐ TOBACCO (IN ANY FORM)	☐ ALCOHOL

(Continue on Reverse)

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MEDICATION HISTORY

☐ BIOPHOSPHONATES (Osteoperosis)	☐ BLOOD THINNERS (Coumadin, Warfarin)

☐ OTHER MEDICATIONS (Including over-the-counter medications, aspirin, natural remedies, etc.)

PLEASE LIST

SURGERIES

Please list any surgeries you have had.

PROBLEMS NOT LISTED

Medical problems NOT listed on this form.

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE