HEALTH HISTORY

Patient Name____ **Birth Date** ____________________

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question)

1. Yes No Has there been a change in your health within the last year?
2. Yes No Have you been hospitalized or treated by a physician in the last three years?
   If YES, why? ____
   Date of last medical exam? ____________ Family physician? ____________________
3. Yes No Have you had problems with prior dental treatment? Date of last dental exam?____________________

II. HAVE YOU EXPERIENCED?

1. Yes No Chest Pain (angina)
2. Yes No Swollen ankles
3. Yes No Shortness of breath
4. Yes No Recent weight loss, fever, or night sweats
5. Yes No Persistent cough, coughing up blood
6. Yes No Excessive bleeding, bruising easily
7. Yes No Sinus problems
8. Yes No Difficulty swallowing
9. Yes No Frequent vomiting or nausea
10. Yes No Dizziness
11. Yes No Ringing in ears
12. Yes No Headaches
13. Yes No Fainting spells
14. Yes No Blurred vision
15. Yes No Seizures
16. Yes No Excessive thirst
17. Yes No Dry mouth
18. Yes No Joint pain, stiffness

III. DO YOU HAVE OR HAVE YOU HAD?

1. Yes No Heart disease
2. Yes No Heart attack or heart defects (inc MVP)
3. Yes No Heart murmurs
4. Yes No Osteoporosis
5. Yes No Stroke or hardening of arteries
6. Yes No High blood pressure
7. Yes No Asthma, TB, emphysema, other lung disease
8. Yes No Hepatitis or other liver disease
9. Yes No Stomach problems or ulcers
10. Yes No Allergies to: drugs, foods, medications, **latex**
    LIST: ____________________________________
    ____
11. Yes No Diabetes
12. Yes No AIDS, HIV
13. Yes No Tumors, cancer
14. Yes No Arthritis, Rheumatism
15. Yes No Eye disease
16. Yes No Skin disease
17. Yes No Anemia
18. Yes No STD (syphilis, gonorrhea)
19. Yes No Herpes
20. Yes No Kidney or bladder disease
21. Yes No Thyroid or adrenal disease
22. Yes No Family history of diabetes, tumors, or heart problems
23. Yes No Are you pregnant or nursing?
24. Yes No Spina Bifida
25. Yes No Cortisone therapy
26. Yes No Psychiatric care
27. Yes No Radiation treatment
28. Yes No Chemotherapy
29. Yes No Prosthetic heart valve
30. Yes No Artificial joint
31. Yes No Hospitalization
32. Yes No Blood transfusions
33. Yes No Surgeries
34. Yes No Pacemaker
35. Yes No Contact lenses

IV. ARE YOU TAKING?

1. Yes No Recreational drugs
2. Yes No Drugs, medications, over-the-counter medicines, natural remedies
3. Yes No Tobacco in any form
4. Yes No Alcohol
5. Yes No Birth control pills

PLEASE LIST: ____
____

V. DO YOU OR HAVE YOU HAD ANY DISEASES OR MEDICAL PROBLEMS *NOT* LISTED ON THIS FORM?

____
____

To the best of my knowledge, I have answered every question completely and accurately. I will inform this office of any changes in my health and/or medication.

Patient/Guardian signature____ Date ____________________