HEALTH HISTORY FORM

YOUR life smiles

Name		Date
Address		
City	State	Zip Code
Home Phone	Work Phone	Mobile Phone
Email	Date of Birth	Sex
Single Married	Name of Spouse	
Occupation		
Closest Relative		Phone

Are completing this form with another person?

What is your relationship with this person?

Referred by

In the following questions, please circle or underline yes or no. Your answers are confidential and for our records only.

1. Are you in good health?	Yes	No
2. Has there been any change in your general health in the past year?	Yes	No
3. My last physical exam was on		
4. Are you now under the care of a physician?	Yes	No
If so, what is the condition that is being treated?		
5. The name, phone and address of your physician is		
6. Have you had any serious illness or operation?	Yes	No
If so, what was the illness or operation?		
7. Have you been hospitalized or had any serious illness within the past five (5) years?	Yes	No
8. Do you have or have you had any of the following diseases or conditions?		
• Damage heart valves or artificial heart valves, including heart murmur	Yes	No
• Congenital heart lesions	Yes	No
• Cardiovascular disease (heart problem, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	Yes	No
• Do you have pain in chest upon exertion?	Yes	No
• Are you ever short of breath after mild exercise?	Yes	No
• Do your ankles swell?	Yes	No
• Do you get short of breath when you lie down?	Yes	No
• Do you require extra pillows when you sleep?	Yes	No
• Do you have a cardiac pacemaker?	Yes	No
• Allergy	Yes	No
• Sinus Trouble	Yes	No
• Asthma or have fever	Yes	No
• Hives or skin rash	Yes	No
• Fainting spells or seizures	Yes	No
• Diabetes	Yes	No
• Do you have to urinate (pass water) more than six times a day?	Yes	No
• Are you thirsty much of the time?	Yes	No
• Does your mouth frequently become dry?	Yes	No

- Hepatitis, jaundice or liver disease Yes No
- Arthritis Yes No
- Inflammatory rheumatism (painful swollen joints) Yes No
- Stomach ulcers Yes No
- Kidney trouble Yes No
- Tuberculosis Yes No
- Do you have a persistent cough or cough up blood? Yes No
- Low blood pressure Yes No
- Venereal disease Yes No
- Epilepsy Yes No
- Psychiatric problems Yes No
- Cancer Yes No
- AIDS or other immunosuppressive disorders Yes No
- Other
- Have you had abdominal bleeding associated with previous extractions, surgery, or trauma? Yes No
- Do you bruise easily? Yes No
- Have you ever required a blood transfusion? Yes No
  If so, explain the circumstances
- Do you have any blood disorder such as anemia? Yes No
- Have you had surgery, x-ray or drug treatment for tumor, growth, or other head or neck condition? Yes No
- Are you taking any drug or medicine? Yes No
  If so, what are you taking?

9. Are you taking any of the following?
   - Antibiotics or sulfa drugs Yes No
   - Anticoagulants (blood thinners) Yes No
   - Medicine for high blood pressure Yes No
   - Cortisone (steroids) Yes No
   - Tranquilizers Yes No
   - Antihistamines Yes No
   - Aspirin Yes No
   - Insulin, tolbutamide (Orinase) or similar drug Yes No
   - Digitalis or drugs for heart trouble Yes No
   - Nitroglycerin Yes No
   - Oral contraceptive or other hormonal therapy Yes No
   - Other

10. Are you allergic or have you reacted adversely to:
    - Local anesthetics Yes No
    - Penicillin or other antibiotics Yes No
    - Sulfa drugs Yes No
    - Barbiturates, sedatives, or sleeping peels Yes No
    - Aspirin Yes No

- Iodine Yes No
- Codeine or other narcotics Yes No
- Other

11. Have you had any serious trouble associated with any previous dental treatment? Yes No
    If so, explain
12. Do you have any disease, condition, or problem not listed above
    that you think I should know about? Yes No
    If so, explain
13. Are you employed in any situation which exposes you regularly
    to x-rays or other ionizing radiation? Yes No
14. Are you wearing contact lenses? Yes No
15. Have you had anything to eat or drink in the last 4 hours? Yes No
16. Are you wearing removable dental appliances? Yes No

Women

18. Are you pregnant? Yes No
19. Do you have any problems associated with you menstrual period? Yes No
20. Are you nursing? Yes No

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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient

Signature of Dentist