Patient Health History

Patient's Name: _____

Physician's Name: _____ Address _____

Has there been any (serious) problem in your general health within the past 5 years? _____

If yes, what was the problem? _____

Date of your last medical check-up: _____ Are you under a physician's care now? _____

If yes, please give reason: _____

What tablets, pills, liquids, or medications do you take? (please include any aspirin, vitamins, tonics, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you *have* or *have you had* any of the following diseases or problems…(Circle Yes or No)

Rheumatic Fever	Yes	No	Hepatitis A, B, or C	Yes	No
Rheumatic Heart Disease	Yes	No	Liver Disease / Jaundice	Yes	No
Heart Murmur	Yes	No	Arthritis	Yes	No
Mitral Valve Prolapse	Yes	No	Kidney Trouble	Yes	No
Prosthetic Joints	Yes	No	Tuberculosis, Emphysema, or other Lung Ailments	Yes	No
Heart Trouble:			Persistent Cough / Cough up Blood	Yes	No
Heart Attack / Heart Surgery	Yes	No	Diabetes	Yes	No
Stroke	Yes	No	Radiation Treatment / Chemotherapy	Yes	No
Congenital Heart Defects	Yes	No	Sores that did not heal within one week	Yes	No
High Blood Pressure	Yes	No	Are you HIV positive?	Yes	No
Low Blood Pressure	Yes	No	Immunosuppressed AIDS	Yes	No
Heart Pacemaker	Yes	No	Do you use Tobacco or Alcohol?	Yes	No
Pain in Chest, Shortness of Breath, Swollen Ankles	Yes	No	Are you Sensitive or Allergic to:		
Venereal Disease, Herpes, Syphilis, Gonorrhea	Yes	No	Latex	Yes	No
Bleeding Problems:			Penicillin	Yes	No
Abnormal Bleeding / Hemophilia	Yes	No	Codeine	Yes	No
Bruises Easily / Anemia	Yes	No	Novocain	Yes	No
Prolonged Healing	Yes	No	Aspirin	Yes	No
Blood Transfusion	Yes	No	Anesthetics	Yes	No
Asthma, Hay Fever	Yes	No	Any other Allergies: _____		
Fainting Spells / Seizures	Yes	No	Women: Are you Pregnant?	Yes	No
			Have you ever taken Fen-phen?	Yes	No

Do you have any disease condition or problem not listed above that you think the doctor should know about? _____

_____

When was your last dental exam? _____ With whom was your last dental exam? _____

"I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any changes occur in my health I am to report it to the dental office as soon as possible. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I have discussed my health history with the doctor."

Date _____ Patient's Signature or Parent/Guardian _____

Date _____ Doctor's Signature _____

Office Use: Vital Signs _____