Health History

Patient's Name: _____ Date: _____

Physician's Name: _____ Type: _____ Date of Last Visit: _____

Do you have or have you ever had any of the following: (circle)

1. Hospitalized for illness or surgery Yes/No
2. Any reaction to:
   a. Aspirin---------- Yes/No
   b. Penicillin---------- Yes/No
   c. Sulfa Drug---------- Yes/No
   d. Erythromycin---------- Yes/No
   e. Codeine---------- Yes/No
   f. Sedatives or Sleeping Pills---------- Yes/No
   g. Dental Anesthetic---------- Yes/No
   h. Latex, Metals, Plastics---------- Yes/No
3. Other Medications---------- Yes/No
   a. Please list----------
4. Hepatitis Type A,B, or C---------- Yes/No
5. Jaundice---------- Yes/No
6. Liver Disease---------- Yes/No
7. Epilepsy/Seizures---------- Yes/No
8. Arthritis---------- Yes/No
9. Sexually Transmitted/Venereal Disease----- Yes/No
10. Scarlet Fever---------- Yes/No
11. Anemia or other Blood Disorders---------- Yes/No
12. Rheumatic Fever---------- Yes/No
13. Prolonged bleeding---------- Yes/No
14. Kidney Disease---------- Yes/No
15. Diabetes---------- Yes/No
16. Stomach of Duodenal Ulcer---------- Yes/No
17. Tuberculosis or Lung Disease---------- Yes/No
18. Emphysema---------- Yes/No
19. Thyroid Parathyroid Disorder---------- Yes/No
20. Heart Disease---------- Yes/No
21. Heart Murmur/Mitral Valve Prolapse---------- Yes/No
22. Arteriosclerosis---------- Yes/No
23. High/Low Blood Pressure---------- Yes/No
24. Implants/Artificial Joint---------- Yes/No
    a. Hip---------- Yes/No
    b. Knee---------- Yes/No
    c. Other---------- Yes/No
25. Swollen Feet or Ankles---------- Yes/No
26. Hives/Skin Rash---------- Yes/No
27. Asthma---------- Yes/No
28. History of Emotional/Nervous Disorders----- Yes/No
29. Psychiatric Treatment---------- Yes/No
30. Tumor or Malignancy---------- Yes/No
31. Radiation Treatment---------- Yes/No
32. Glaucoma---------- Yes/No
33. Prostate Disorders (male)---------- Yes/No
34. Immune Suppressed Disorder---------- Yes/No
35. HIV/Aids---------- Yes/No
36. Contact Lenses---------- Yes/No
37. Weight Loss Unexplained---------- Yes/No
38. Stroke---------- Yes/No

Are You:

39. Presently being treated for any illness-------- Yes/No
40. Aware of any changes in general health in the past year---------- Yes/No
41. Often Thirsty---------- Yes/No
42. Urinating more than six times per day-------- Yes/No
43. Often exhausted or fatigued---------- Yes/No
44. Smoke or use tobacco---------- Yes/No
45. Subject to frequent headaches---------- Yes/No
46. Generally nervous person---------- Yes/No

Women: Are You:

47. Are you Pregnant---------- Yes/No
48. Taking Birth Control Pills or other Hormones---------- Yes/No
49. Presently in Menopause---------- Yes/No
50. Past Menopause---------- Yes/No

Please explain any <u>Yes</u> answers above

_____
_____
_____
_____

Please list any of the medications you are taking

_____
_____
_____
_____

If there are any changes in my medical history, I will notify the Dentist.

Patient Signature: _____

Date: _____

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____