



Health History

Please answer all questions by circling "Yes" or "No" and fill in all blank spaces when indicated if applicable.

Patient's Name _____ Date _____

Physician's Name _____ Telephone _____

Physician's Address _____ Date of last visit _____

No Yes ... Has there been any change in your general health within the past year?
If yes, what is the change? _____

No Yes ... Are you now under a physician's care? If yes, what condition is being treated? _____

No Yes ... Have you ever been hospitalized or had a serious illness during the past 5 years? If
Yes, what was the problem? _____

No Yes ... Do you use tobacco in any form? _____

No Yes ... Do you consume alcoholic beverages? _____

Do you have, or have you had any of the following:

No Yes ... Tire easily, weakness?

No Yes ... Marked weight change?

No Yes ... Night sweats?

No Yes ... Persistent fever?

No Yes ... Persistent swollen glands?

No Yes ... Sinus problems?

No Yes ... Seizures or convulsions?

No Yes ... Psychiatric treatment?

No Yes ... Shortness of breath when you lie down?

No Yes ... Asthma, hay fever, difficulty breathing?

No Yes ... A persistent cough, or coughing up blood?

No Yes ... Tuberculosis or emphysema?

No Yes ... Diabetes?

No Yes ... Frequent urination (more than 6 times a day)?

No Yes ... Excessive thirst?

No Yes ... Thyroid disease?

No Yes ... Rheumatic fever or rheumatic heart disease?

No Yes ... Heart murmur, mitral valve prolapse, or congenital heart disease?

No Yes ... Heart trouble, heart attack, stroke, pace maker, or prosthetic heart valve?

No Yes ... Shortness of breath or chest pain after mild exertion (angina)?

No Yes ... High blood pressure?

No Yes ... Arthritis?

No Yes ... Do you have any artificial bones or joints (prosthesis) implanted?

No Yes ... Hepatitis, jaundice, or liver disease? If yes, which type A ___ B ___ Non A / Non B ___

No Yes ... Stomach ulcers?

- No Yes ... Kidney trouble or renal dialysis?
- No Yes ... Venereal disease, gonorrhea, syphilis?
- No Yes ... Do you have blood in your urine or urethral discharge?
- No Yes ... Do you have any blood or bleeding disorders (like anemia)?
- No Yes ... Do you bleed excessively after you are cut or bruise easily?
- No Yes ... Have you ever required a blood transfusion?
- No Yes ... Have you ever been denied permission to give blood?
- No Yes ... Cancer? If yes, where? _____
- No Yes ... Have you had surgery or radiation (x-ray) treatment for tumor, growth, cancer, or other condition of the head, neck, or mouth? If yes, where? _____
- No Yes ... Do you have any hearing, visual problems, or other disabilities which we should consider in planning your dental care (eg. glaucoma)? If yes, what? _____
- No Yes ... Have you been in contact with any individual having hepatitis, tuberculosis, or AIDS?
- No Yes ... Do you have AIDS, ARC or positive antibody test for HTLV-III?
- No Yes ... Family History of Heart disease, diabetes, or immunologic disease? If yes, what _____

Have you taken any of the following medications in the past six months:

- No Yes ... Anticoagulants (blood thinners)?
- No Yes ... Blood pressure medication or water pills?
- No Yes ... Cortisone or steroids?
- No Yes ... Valium, Librium, or tranquilizers?
- No Yes ... Insulin or pills for diabetes?
- No Yes ... Digitalis or drugs for a heart problem?
- No Yes ... Nitroglycerin?
- No Yes ... Aspirin?
- No Yes ... Dilantin?
- No Yes ... Birth control pills?
- No Yes ... Recreational drugs?
- No Yes ... Other medications and dosage? _____

Are you allergic or have had any reaction to:

- No Yes ... Novocaine or dental anesthetics? If yes, what? _____
- No Yes ... Penicillin, erythromycin, or other antibiotics? If yes, what? _____
- No Yes ... Aspirin?
- No Yes ... Codeine or other narcotic? If yes, what? _____
- No Yes ... Other allergies? _____

No Yes ... Women: Are you pregnant or anticipating pregnancy in the near future?

Do you have any disease, condition, or problem not listed above that you think I should know about? Please describe. _____

To the best of my knowledge, all the preceding answers are true and correct.

Signature of patient, parent, or guardian _____ date _____

B.P. ____ / ____ Pulse _____