CONFIDENTIAL HEALTH HISTORY

Patient Name: ____ Date of Birth: _____________________________________

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

1. Yes / No Is your general health good?
   If NO, explain: ____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: ____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: ____
4. Yes / No Are you being treated by a physician now? If YES, explain: ____
   Date of last medical exam? _______________________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _______________________________ _
   Date of last dental exam: _________________
6. Yes / No Are you in pain now?
   If YES, explain: ________________________ ____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (please circle Yes or No for each)

Yes/No	Chest pain (angina)	Yes/No	Blood in stools	Yes/No	Frequent vomiting
Yes/No	Fainting spells	Yes/No	Diarrhea or constipation	Yes /No	Jaundice
Yes/No	Recent significant weight loss	Yes /No	Frequent urination	Yes/No	Dry mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes /No	Night sweats	Yes/No	Ringing in ears	Yes/No	Difficulty swallowing
Yes/No	Persistent cough	Yes/No	Headaches	Yes/No	Swollen ankles
Yes /No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of breath ,
Yes /No	Blood in urine	Yes/No	Bruise easily	Yes/No	Sinus problems

Ill. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Heart disease	Yes/No	Asthma (Date of last attack______)	Yes/No	Tumors or cancer
Yes/No	Family history of heart disease	Yes/No	Emphysema or other lung disease	Yes/No	Radiation
Yes/No	Heart attack	Yes/No	Psychiatric care	Yes /No	Chemotherapy
Yes/No	Artificial joint	Yes/No	Eating disorders	Yes/No	Tuberculosis
Yes/No	Artificial Heart valves	Yes/No	Gastric Bi-pass Surgery	Yes/No	AIDS/HIV
Yes/No	Heart defects	Yes/No	Hospitalization	Yes/No	Sexual transmitted disease
Yes/No	Heart murmurs	Yes/No	Surgeries	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Gastro/Intestinal Disease	Yes/No	Canker or cold sores
Yes/No	Hardening of arteries	Yes/No	Liver disease	Yes/No	Skin disease
Yes/No	High blood pressure	Yes/No	Hepatitis	Yes/No	Arthritis, rheumatism
Yes/No	Pace Maker	Yes/No	Stomach problems or ulcers	Yes/No	Osteoporosis
Yes/No	Stroke	Yes/No	Kidney or bladder disease	Yes/No	Organ Transplants
Yes/No	Bleeding Disorders	Yes/No	Diabetes	Yes/No	Eye disease
Yes/No	Anemia	Yes/No	Family history of diabetes	Yes/No	Seizures
Yes/No	Leukemia	Yes/No	Thyroid disease		

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Aspirin	Yes /No	Valium	Yes /No	Tetracycline
Yes/No	Darvon	Yes/No	Demerol	Yes/No	Vicodin
Yes/No	Codeine	Yes/No	Penicillm	Yes/No	Percodan
Yes/No	Latex	Yes/No	Food	Yes/No	Nitrous oxide
Yes/No	Local anesthetic (Novocain or Xylocaine)	Yes/No	Erythromycin	Yes/No	Metal

Others:

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(please circle Yes or No for each)

Yes /No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes/No Aspirin

List medications (including herbal supplements) presently taken and for what condition: ______________________________ _

VI. WOMEN ONLY (please circle Yes or No for each)

Yes/No Are you or could you be pregnant? If YES, what month? ____ _
Yes/No Are you nursing?
Yes /No Are you taking birth control pills?

VII. ALL PATIENTS (please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____
____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ______________________________________ _
Yes / No Have you ever taken Fen-Phen? If YES, when: ____
Yes/ No Have you or any family member ever been told ***not*** to have general anesthesia or sedation by a medical professional?

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

1 authorize the dentist to contact my physician.

Patient's Signature: ____ _ Date: ___________________________

Physician's Name: ____ Phone Number:__________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, 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 (parent or Guardian) _____ Date _______________ Signature of Dentist _____ Date

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
______	__________________________	____	_______
______	__________________________	____	_______
______	__________________________	____	_______
______	__________________________	____	_______