Confidential Health History

Patient Name: ____ Date of Birth: ________________________

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

Yes / No Is your general health good?
If NO, please explain: ____

Yes / No Has there been a change to your health within the last year?
If YES, please explain: ____

Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
If YES, please explain: ____

Yes / No Are you currently being seen by a physician for any conditions?
If YES, please explain: ____
Date of last medical exam: ________________ Reason for exam: ______________________________

Yes / No Have you had problems or complications with prior dental treatment?
If YES, please explain: ____

II. HAVE YOU EVER 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

Other: ____

III. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	HIV / AIDS	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Seizures	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Stroke	Yes / No	Eye disease
Yes / No	Emphysema or other lung disease	Yes / No	Cosmetic surgery	Yes / No	Transplants
Yes / No	Kidney or bladder disease	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: ____

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

Yes / No	Penicillin or other antibiotics	Yes / No	Local anesthetic	Yes / No	Aspirin
Yes / No	Valium or other sedatives	Yes / No	Nitrous oxide	Yes / No	Metal
Yes / No	Codeine or other narcotics	Yes / No	Latex	Yes / No	Food

Other: ____

(Form continues on back of page)

V. **HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS?** (Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Anti-depressants	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Herbal supplements	Yes / No	Aspirin

Other: ____

List of current medications:

____

____

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

Yes / No Are you or could you be pregnant? If YES, estimated due date: ______________________

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 used any form of tobacco?
If YES, please explain: ____

Yes / No Have you ever taken IV or oral bisphosphonates (for example, Fosamax)?
If YES, please explain: ____

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

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 dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________________ Date: ______________

Physician's Name: ________________________ Physician's Phone: ____________

Whom would you like us to contact in case of an emergency?

Name: ________________ **Relationship:**__________ **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
________	________________	______________________________	________
________	________________	______________________________	________
________	________________	______________________________	________