

PATIENT NAME: \_\_\_\_\_ SOC. SEC. NO: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

I. CIRCLE APPROPRIATE ANSWER (LEAVE BLANK IF YOU DO NOT UNDERSTAND THE QUESTION):

- 1. YES NO IS YOUR GENERAL HEALTH GOOD?
2. YES NO HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?
3. YES NO HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS? IF YES, WHY?
4. YES NO ARE YOU BEING TREATED BY A PHYSICIAN NOW? FOR WHAT?
DATE OF LAST MEDICAL EXAM?
DATE OF LAST DENTAL EXAM?
5. YES NO HAVE YOU HAD ANY PROBLEMS WITH PRIOR DENTAL TREATMENT?
6. YES NO ARE YOU IN PAIN NOW?

II. HAVE YOU EXPERIENCED:

- 7. YES NO CHEST PAIN (ANGINA)
8. YES NO SWOLLEN ANKLES?
9. YES NO SHORTNESS OF BREATH?
10. YES NO RECENT WEIGHT LOSS, FEVER, NIGHT SWEATS
11. YES NO PERSISTENT COUGH, COUGHING UP BLOOD?
12. YES NO BLEEDING PROBLEMS, BRUISING EASILY
13. YES NO SINUS PROBLEMS?
14. YES NO DIFFICULTY SWALLOWING?
15. YES NO DIARRHEA, CONSTIPATION, BLOOD IN STOOL
16. YES NO FREQUENT VOMITING, NAUSEA?
17. YES NO DIFFICULTY URINATING, BLOOD IN URINE?
18. YES NO DIZZINESS?
19. YES NO RINGING IN EARS?
20. YES NO HEADACHES?
21. YES NO FAINTING SPELLS?
22. YES NO BLURRED VISION?
23. YES NO SEIZURES?
24. YES NO EXCESSIVE THIRST?
25. YES NO FREQUENT URINATION?
26. YES NO DRY MOUTH?
27. YES NO JAUNDICE?
28. YES NO JOINT PAIN, STIFFNESS?

III. DO YOU HAVE OR HAVE YOU HAD:

- 29. YES NO HEART DISEASE?
30. YES NO HEART ATTACK, HEART DEFECTS?
31. YES NO HEART MURMURS?
32. YES NO RHEUMATIC FEVER?
33. YES NO STROKE, HARDENING OF ARTERIES?
34. YES NO HIGH BLOOD PRESSURE?
35. YES NO ASTHMA, TB, EMPHYSEMA, OTHER LUNG DISEASES?
36. YES NO HEPATITIS, OTHER LIVER DISEASES?
37. YES NO STOMACH PROBLEMS, ULCERS?
38. YES NO ALLERGIES TO: DRUGS, FOODS, MEDICATIONS, LATEX?
39. YES NO FAMILY HISTORY OF DIABETES, HEART PROBLEMS, TUMORS?
40. YES NO AIDS?
41. YES NO TUMORS, CANCER?
42. YES NO ARTHRITIS, RHEUMATISM?
43. YES NO EYE DISEASES?
44. YES NO SKIN DISEASES?
45. YES NO ANEMIA?
46. YES NO VD (SYPHILIS OR GONORRHEA)?
47. YES NO HERPES?
48. YES NO KIDNEY, BLADDER DISEAS?
49. YES NO THYROID, ADRENAL DISEASE?
50. YES NO DIABETES?

IV. DO YOU HAVE OR HAVE YOU HAD:

- 51. YES NO PSYCHIATRIC CARE?
52. YES NO RADIATION TREATMENT?
53. YES NO CHEMOTHERAPY?
54. YES NO PROSTHETIC HEART VALVE?
55. YES NO ARTIFICIAL JOINT?
56. YES NO HOSPITALIZATION?
57. YES NO BLOOD TRANSFUSION?
58. YES NO SURGERIES?
59. YES NO PACEMAKER?
60. YES NO CONTACT LENSES?

V. ARE YOU TAKING OR HAVE YOU TAKEN:

- 61. YES NO RECREATIONAL DRUGS?
62. YES NO DRUGS, MEDICATIONS, OVER-THE-COUNTER MEDICINES (INCLUDING ASPRIN), NATURAL REMEDIES, FEN PHEN?
63. YES NO TOBACCO IN ANY FORM?
64. YES NO ALCOHOL?

PLEASE LIST: \_\_\_\_\_

VI. WOMEN ONLY:

- 65. YES NO ARE YOU OR COULD YOU BE PREGNANT OR NURSING?
66. YES NO TAKING BIRTH CONTRL PILLS?

VII. ALL PATIENTS:

- 67. YES NO DO YOU HAVE OR HAVE YOU HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM? IF YES, PLEASE EXPLAIN: \_\_\_\_\_

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.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RECALL REVIEW:

- 1. PATIENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_
2. PATIENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_
3. PATIENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT HEALTH HISTORY