Confidential Health History Form

Patient Name: _____ **Date of Birth** _____

I. Please Mark with an "X" (Leave blank if you do not understand the question)

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

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Please Mark with an X)

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

III.HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING (Please Mark with an X)

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

IV. ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING (Please Mark with an X)

Yes	No		Yes	No		Yes	No	
◯	◯	Aspirin	◯	◯	Valium	◯	◯	Tetracycline
◯	◯	Darvon	◯	◯	Demerol	◯	◯	Vicodin
◯	◯	Codeine	◯	◯	Penicillin	◯	◯	Percodan
◯	◯	Local anesthetic	◯	◯	Latex	◯	◯	Food
◯	◯	Nitrous oxide	◯	◯	Erythromycin	◯	◯	Metal

Others:_____

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V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Mark with an X)

Yes	No		Yes	No		Yes	No	
___	___	Recreational drugs	___	___	Tobacco in any form	___	___	Antibiotics
___	___	Over-the-counter medicines	___	___	Alcohol	___	___	Supplements
___	___	Weight loss medications	___	___	Intravenous bisphosphonates	___	___	Aspirin

Please list:_____

VI. Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? YES ___ NO ___

If YES, please explain:_____

VII. LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

VIII.WOMEN ONLY

Yes	No	
___	___	Are you or could you be pregnant?
___	___	Are you nursing?
___	___	Are you taking birth control pills?

IX. ALL PATIENTS

Yes	No	
___	___	Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain:_____

_____

___ ___ Have you ever taken Fen-phen? If YES, when?_____

___ ___ 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.

I authorize the dentist to contact my physician._____(please initial)

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