

Health History

Date: ____/____/____ Circle One: MR. MRS. MISS

Name: _____ Birthdate: _____

When was your last visit to a dental office? _____

Do you have any pain associated with your teeth, gums, mouth, or jaw? YES NO

If YES Please Explain _____

What is the main reason for your visit? _____

Your Physician's Name: _____

Your Physician's Phone Number: () _____ - _____

For the following questions, check either YES or NO

- | | YES | NO |
|--|-------|-------|
| 1. Are you in good health..... | _____ | _____ |
| 2. Do you get regular medical check ups..... | _____ | _____ |
| 3. Have you had any serious illness or operation..... | _____ | _____ |
| If YES please list illness & date of treatment _____ | | |
| _____ | | |
| _____ | | |
| 4. Any heart problems (congenital disease, damaged/artificial valves, arteriosclerosis, coronary occlusion, murmurs, heart attack, angina, pacemaker, etc.)_____ | _____ | _____ |
| 5. High Blood Pressure..... | _____ | _____ |
| 6. Hepatitis | _____ | _____ |
| 7. Tuberculosis..... | _____ | _____ |
| 8. HIV/AIDS..... | _____ | _____ |
| 9. Diabetes..... | _____ | _____ |
| 10. Inflammatory rheumatism..... | _____ | _____ |
| 11. Prosthetic joints (implants, plates, screws etc.)..... | _____ | _____ |
| 12. Kidney trouble..... | _____ | _____ |
| 13. Cancer..... | _____ | _____ |
| 14. Chemotherapy/Radiation Therapy..... | _____ | _____ |
| 15. Seizures or fainting spells..... | _____ | _____ |
| 16. Stroke..... | _____ | _____ |
| 17. Blood disorder/problem..... | _____ | _____ |
| 18. Arthritis | _____ | _____ |
| 19. Herpes..... | _____ | _____ |
| 20. Liver disease..... | _____ | _____ |
| 21. Sinus trouble | _____ | _____ |
| 22. Stomach ulcer..... | _____ | _____ |
| 23. Asthma..... | _____ | _____ |
| 24. Depression/ Anxiety / Nervousness..... | _____ | _____ |
| 25. Allergies (local anesthetics, penicillin/antibiotics, codeine, sulfa, latex, etc.)_____ | _____ | _____ |
| _____ | | |
| 26. Are you taking any medications (antibiotics, anticoagulants, blood pressure, steroids, tranquilizers, aspirin, antihistamine, insulin, nitroglycerin, oral contraceptives, hormonal therapy, etc.)_____ | _____ | _____ |
| _____ | | |
| 27. Recreational drugs..... | _____ | _____ |
| 28. Pregnant or Nursing..... | _____ | _____ |
| 29. Any problems/conditions not listed_____ | _____ | _____ |
| _____ | | |

I have read the foregoing & have filled out this health questionnaire completely and truthfully.

SIGNATURE of PATIENT or GUARDIAN _____ DATE _____

SIGNATURE of DENTIST _____ DATE _____