HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Have you had a chest cold, cough or flu symptoms producing sputum in the last two weeks?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Are you limited in your ability to perform your everyday tasks (working around the house or in the yard, walking 2 blocks or climbing a flight of stairs)? If yes, circle applicable cause below:
   A. Short of Breath B. Fatigue C. Physical Limitation D. Chest Pain E. Other
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 anesthesia in the past?
6. Yes No Do you have problems opening your mouth fully or tilting your head back?
7. Yes No Have you had prior anesthesia problems? If so, describe:
   _____

II. HAVE YOU EXPERIENCED:

8.	Yes	No	Chest pain (angina)?	16.	Yes	No	Frequent vomiting, nausea?
9.	Yes	No	Swollen ankles?	17.	Yes	No	Headaches?
10.	Yes	No	Shortness of breath?	18.	Yes	No	Fainting spells?
11.	Yes	No	Recent weight loss, fever, night sweats?	19.	Yes	No	Seizures?
12.	Yes	No	Persistent cough, coughing up blood?	20.	Yes	No	Excessive thirst?
13.	Yes	No	Bleeding problems, bruising easily?	21.	Yes	No	Frequent urination?
14.	Yes	No	Sinus problems?	22.	Yes	No	Jaundice?
15.	Yes	No	Difficulty swallowing?	23.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

24.	Yes	No	Hypertension?	50.	Yes	No	Stomach ulcer?
25.	Yes	No	Heart murmur?	51.	Yes	No	Diabetes?
26.	Yes	No	Hx of rheumatic fever	52.	Yes	No	Thyroid disease?
27.	Yes	No	Mitral valve prolapse?	53.	Yes	No	Kidney failure?
28.	Yes	No	Heart attack?	54.	Yes	No	Kidney stone?
29.	Yes	No	Heart problems (other)?	55.	Yes	No	Kidney infections?
30.	Yes	No	Heart failure?	56.	Yes	No	Kidney dialysis?
31.	Yes	No	CHD?	57.	Yes	No	Anemia/low blood count?
32.	Yes	No	Congestive heart failure?	58.	Yes	No	Bruising?
33.	Yes	No	Chronic CHF?	59.	Yes	No	Bleeding problems?
34.	Yes	No	Irregular heartbeat?	60.	Yes	No	Stroke/TIA?
35.	Yes	No	Pacemaker?	61.	Yes	No	Epilepsy?
36.	Yes	No	Internal defibrillator?	62.	Yes	No	Alzheimer's?
37.	Yes	No	Asthma?	63.	Yes	No	Parkinson's disease?
38.	Yes	No	COPD?	64.	Yes	No	Glaucoma?
39.	Yes	No	Emphysema?	65.	Yes	No	History of cataracts?
40.	Yes	No	Chronic bronchitis?	66.	Yes	No	Headaches?
41.	Yes	No	Tuberculosis/positive TB test?	67.	Yes	No	Restless leg syndrome?
42.	Yes	No	Sleep apnea?	68.	Yes	No	Spinal cord injury?
43.	Yes	No	Require CPAP?	69.	Yes	No	Artificial joint?
44.	Yes	No	Frequent heartburn?	70.	Yes	No	Arthritis?
45.	Yes	No	Gastric reflux?	71.	Yes	No	Seizures?
46.	Yes	No	Hiatal hernia?	72.	Yes	No	Depression?
47.	Yes	No	Cirrhosis?	73.	Yes	No	Anxiety?
48.	Yes	No	Hepatitis?	74.	Yes	No	Mental illness?
49.	Yes	No	Gallbladder disease?	75.	Yes	No	Chemotherapy/radiation?

IV. ADDITIONAL INFO:

76. Yes No Do your medications include blood thinner (i.e. Coumadin, Plavix, or Aspirin)?
77. Yes No Do your medications include bone density medications/bisphosphonates (i.e. Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva)?
78. Yes No Are you allergic to medications, soybeans, eggs, or sulfites? If so, please list:_____
    _____
79. Yes No Are you allergic to latex?
80. Yes No Do you have a prosthetic joint replacement? If so, where and when was it replaced?_____
    _____

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	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 control 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 so, 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: _____