## **HEALTH HISTORY**

## English

Patient Name:			Patient Identification Number:						
			Birth Date:						
I. CIRC	CLE API	PROPRIA	ATE 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:						

8.YesNoChest pain (angina)?16.YesNoFrequent vomitting, nausea?9.YesNoSwollen ankles?17.YesNoHeadaches?10.YesNoRecent weight loss, fever, night sweats?19.YesNoSeizures?11.YesNoRecent weight loss, fever, night sweats?19.YesNoSeizures?12.YesNoBleeding problems, bruising easily?21.YesNoFrequent urination?14.YesNoSinus problems?22.YesNoJaundice?15.YesNoDifficulty swallowing?23.YesNoJaundice?24.YesNoHeart murrur?50.YesNoStomach ulcer?25.YesNoHeart murrur?51.YesNoDiabetes?26.YesNoHeart throblems (other)?52.YesNoHiderige?27.YesNoHeart throblems (other)?53.YesNoKidney stone?28.YesNoHeart failure?54.YesNoKidney stone?29.YesNoHeart failure?55.YesNoKidney dialysi?31.YesNoChronic CH??55.YesNoAnemia/low blood count?32.YesNoHeart failure?57.YesNoAnemia/low blood count?33.YesNoChronic cH?? <th>II. HAV</th> <th>VE YOU</th> <th>EXPER</th> <th>IENCED:</th> <th></th> <th></th> <th></th> <th></th>	II. HAV	VE YOU	EXPER	IENCED:				
9. Yes No Swollen ankles? 17. Yes No Headaches?   10. Yes No Recent weight loss, fever, night sweats? 19. Yes No Seizures?   11. Yes No Recent weight loss, fever, night sweats? 19. Yes No Execssive thirst?   12. Yes No Bleeding problems, bruising easily? 20. Yes No Execssive thirst?   13. Yes No Bleeding problems, bruising easily? 22. Yes No Jaundice?   14. Yes No Difficulty swallowing? 23. Yes No Jaundice?   15. Yes No Hypertension? 50. Yes No Stomach ulcer?   25. Yes No Hart murmur? 51. Yes No Kidney failure?   26. Yes No Hitral valve prolapse? 53. Yes No Kidney failure?   28. Yes No Heart trailure? 54. Yes No Kidney dialysis?   30. Yes No Heart failure? 58. Yes No Kidney dialysis?   31. Yes No Congetive heart failure? 58. Yes No Bleeding problems? <td>8.</td> <td>Yes</td> <td>No</td> <td>Chest pain (angina)?</td> <td>16.</td> <td>Yes</td> <td>No</td> <td>Frequent vomiting, nausea?</td>	8.	Yes	No	Chest pain (angina)?	16.	Yes	No	Frequent vomiting, nausea?
11.YesNoRecent weight loss, fever, night sweats?19.YesNoSeizures?12.YesNoBleeding problems, bruising easily?21.YesNoExcessive thirst?13.YesNoBleeding problems, bruising easily?22.YesNoFrequent urination?14.YesNoSinus problems?22.YesNoJaundice?15.YesNoDifficulty swallowing?23.YesNoJoint pain, stiffness?11.DO YOU HAVE OR HAVE YOU HADETestTestTestTestTest24.YesNoHypertension?50.YesNoStomach ulcer?25.YesNoHaett murmur?51.YesNoDiabetes?26.YesNoHaett murmur?53.YesNoKidney failure?28.YesNoHeatt ratack?54.YesNoKidney failure?29.YesNoHeatt ratack?54.YesNoKidney failure?20.YesNoHeatt failure?56.YesNoAnemia/low blood count?30.YesNoCongestive heart failure?57.YesNoBleeding problems?31.YesNoChronic CHF?59.YesNoBleeding problems?33.YesNoChronic CHF?59.YesNoBleeding problems?34.YesNoInreal defibrillat	9.	Yes	No		17.	Yes	No	Headaches?
12.YesNoPersistent cough, coughing up blood?20.YesNoExcessive thirst?13.YesNoBleeding problems, bruising easily?21.YesNoFrequent urination?14.YesNoDifficulty swallowing?22.YesNoJoint pain, stiffness?15.YesNoDifficulty swallowing?23.YesNoJoint pain, stiffness?24.YesNoHypertension?50.YesNoStomach ulcer?25.YesNoHart murmur?51.YesNoThyroid disease?26.YesNoHart murmur?51.YesNoThyroid disease?27.YesNoHeart murmur?53.YesNoKidney stone?28.YesNoHeart fattack?54.YesNoKidney stone?29.YesNoHeart problems (other)?55.YesNoKidney stone?30.YesNoChronic CHF?58.YesNoBruising?31.YesNoChronic CHF?59.YesNoBruising?33.YesNoChronic CHF?59.YesNoBruising?34.YesNoIrregular heartbeat?60.YesNoBruising?35.YesNoAsthma?63.YesNoBruising?36.YesNoInregular heartbeat?60.YesNoB	10.	Yes	No	Shortness of breath?	18.	Yes	No	Fainting spells?
13. YesNoBleeding problems, bruising easily?21. YesNoFrequent urination?14. YesNoSinus problems?22. YesNoJaundice?15. YesNoDifficulty swallowing?23. YesNoJoint pain, stiffness? <b>II.DO YOU HAVE OR HAVE YOU HAD:</b> 24. YesNoHypertension?50. YesNoStomach ulcer?25. YesNoHeart murmur?51. YesNoDiabetes?26. YesNoHx of theumatic fever52. YesNoKidney failure?28. YesNoHeart attack?54. YesNoKidney failure?29. YesNoHeart attack?55. YesNoKidney infections?30. YesNoHeart failure?56. YesNoKidney dialysis?31. YesNoChoraic CHP?57. YesNoAnemia/low blood count?32. YesNoChoraic CHP?59. YesNoBleeding problems?33. YesNoChronic CHP?59. YesNoBleeding problems?34. YesNoInternal defibrillator?62. YesNoAstheriace??35. YesNoInternal defibrillator?63. YesNoParkinson's disease?34. YesNoInternal defibrillator?63. YesNoHistory of cataracts?40. YesNoEmphysema?65. YesNoHistory of cataracts?40. YesNoEmphysema?65. YesNoHeadaches?41. YesNo <td< td=""><td>11.</td><td>Yes</td><td>No</td><td>Recent weight loss, fever, night sweats?</td><td>19.</td><td>Yes</td><td>No</td><td>Seizures?</td></td<>	11.	Yes	No	Recent weight loss, fever, night sweats?	19.	Yes	No	Seizures?
14.YesNoSinus problems?22.YesNoJaundice?15.YesNoDifficulty swallowing?23.YesNoJoint pain, stiffness?III. DO YOU HAVE OR HAVE YOU HAD:24.YesNoHypertension?50.YesNoStomach ulcer?25.YesNoHeart murmur?51.YesNoDiabetes?26.YesNoMitral valve prolapse?53.YesNoKidney failure?28.YesNoHeart attack?54.YesNoKidney failure?29.YesNoHeart failure?55.YesNoKidney failure?30.YesNoHeart failure?56.YesNoKidney failysi?31.YesNoChorle failure?57.YesNoAnemia/ow blood count?32.YesNoChorle failure?57.YesNoBleeding problems?33.YesNoChorle CHF?59.YesNoBleeding problems?34.YesNoIntregular heartbeat?60.YesNoEpileps?35.YesNoIntregular heartbeat?61.YesNoBleeding problems?36.YesNoAsthma?63.YesNoHeart failur?37.YesNoAsthma?63.YesNoHeart failur?38.YesNoAsthma?65.Ye	12.	Yes	No	Persistent cough, coughing up blood?	20.	Yes	No	Excessive thirst?
15. YesNoDifficulty swallowing?23. YesNoJoint pain, stiffness? <b>III. DO YOU HAVE OR HAVE YOU HAD:</b> 24. YesNoHeart murmur?50. YesNoStomach ulcer?25. YesNoHeart murmur?51. YesNoDiabetes?26. YesNoHaxt prolapse?53. YesNoKidney failure?28. YesNoHeart attack?54. YesNoKidney failure?29. YesNoHeart problems (other)?55. YesNoKidney infections?30. YesNoHeart failure?56. YesNoKidney dialysis?31. YesNoCongestive heart failure?58. YesNoAnemia/low blood count?22. YesNoChronic CHF?59. YesNoAnemia/low blood count?33. YesNoChronic CHF?59. YesNoBleeding problems?34. YesNoIntergular heartbeat?60. YesNoStroke/TIA?35. YesNoIntergular heartbeat?61. YesNoAlzhimson's disease?37. YesNoAsthma?63. YesNoParkinson's disease?38. YesNoEmphysema?65. YesNoHistory of cataracts?40. YesNoChronic bronchitis?64. YesNoHeatdaches?41. YesNoThemphysema?65. YesNoHeatdaches?42. YesNoStepa panea?65. YesNoHeatdaches?44. YesNoFequent heartbur?71. Ye	13.	Yes	No	Bleeding problems, bruising easily?	21.	Yes	No	Frequent urination?
III. DO YOU HAVE OR HAVE YOU HAD:24.YesNoHypertension?50.YesNoStomach ulcer?25.YesNoHx of rheumatic fever51.YesNoDiabetes?26.YesNoMitral valve prolapse?53.YesNoKidney failure?28.YesNoHeart attack?54.YesNoKidney failure?29.YesNoHeart attack?54.YesNoKidney failure?30.YesNoHeart failure?55.YesNoKidney dialysis?31.YesNoHeart failure?56.YesNoKidney dialysis?31.YesNoCongestive heart failure?58.YesNoAnemia/tow blood count?32.YesNoChronic CHF?59.YesNoBleeding problems?33.YesNoInregular heartbeat?60.YesNoEpilepsy?34.YesNoPacemaker?61.YesNoEpilepsy?35.YesNoInternal defibrillator?62.YesNoAlzheimer's?37.YesNoChronic bronchitis?64.YesNoGlaucoma?39.YesNoEmphysema?65.YesNoHeadaches?41.YesNoChronic bronchitis?66.YesNoHeadaches?39.YesNoChronic bronchitis?6	14.	Yes	No	Sinus problems?	22.	Yes	No	Jaundice?
24.YesNoHypertension?50.YesNoStomach ulcer?25.YesNoHeart murmu?51.YesNoDiabetes?26.YesNoHx of rheumatic fever52.YesNoThyroid disease?27.YesNoMitral valve prolapse?53.YesNoKidney failure?28.YesNoHeart attack?54.YesNoKidney stone?29.YesNoHeart failure?55.YesNoKidney infections?30.YesNoHeart failure?55.YesNoKidney infections?30.YesNoHeart failure?55.YesNoKidney infections?30.YesNoCHD?57.YesNoAnemia/low blood count?31.YesNoCongestive heart failure?58.YesNoBleeding problems?33.YesNoChronic CHF?59.YesNoBleeding problems?34.YesNoPacemaker?61.YesNoEpileps?35.YesNoPacemaker?63.YesNoParkinson's disease?36.YesNoCOPD?64.YesNoGlaucoma?39.YesNoChronic bronchitis?65.YesNoHeatacts?40.YesNoChronic bronchitis?65.YesNoHeatacts?41.Yes<	15.	Yes	No	Difficulty swallowing?	23.	Yes	No	Joint pain, stiffness?
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48. Yes No Hepatitis? 74. Yes No Mental illness?								
1								
49. Yes No Gallbladder disease? 75. Yes No Chemotherapy/radiation?								
	49.	Yes	No	Gallbladder disease?	75.	Yes	No	Chemotherapy/radiation?

## IV. ADDITIONAL INFO:

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

## 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?
Pleas	e list:						

VI. WOMEN ON	NLY:								
65. Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?			
VII. ALL PATIE	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 signat	ture:				Date:				
RECALL REVIEW:									
1. Patient's signature Date:									
2. Patient's sign	2. Patient's signature Date:								
3. Patient's sign					Date:				