

**HEALTH HISTORY**

**PATIENT NAME:** \_\_\_\_\_

*Please check yes or no:*

**1. Has there been any change in your health within the past year ?**  
 Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**2. Are you now under the care of a physician?**  
 Yes  No

If yes, who: \_\_\_\_\_  
Reason: \_\_\_\_\_

**3. Have you had any serious illness or operations?**  
 Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**4. Have you ever been hospitalized in the past?**  
 Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**5. Do you require Antibiotics prior to Dental Procedures?**  
 Yes  No

**6. Do you have, or have you had any of the following:**

**Heart Problems:**

- Rheumatic Fever:  Yes  No
- Rheumatic Heart Disease:  Yes  No
- Congenital Heart Defect:  Yes  No
- Heart Attack:  Yes  No
- Heart Murmur:**  Yes  No
- Heart Valve Problems:  Yes  No
- High blood pressure:  Yes  No
- Irregular/rapid heart beat:  Yes  No
- Chest pains:**  Yes  No
- Shortness of breath:  Yes  No
- Swollen ankles:  Yes  No

**Lung Problems:**

- Asthma:  Yes  No
- Bronchitis:  Yes  No
- Tuberculosis:  Yes  No
- Emphysema:  Yes  No

**Liver Problems:**

- Hepatitis:  Yes  No
- Jaundice:  Yes  No

**Kidney Problems:**

- Urinary Tract Infections:  Yes  No
- Burning during urination:  Yes  No
- Frequent urination:  Yes  No
- Blood in the urine:  Yes  No

**Blood Problems:**

- Anemia:  Yes  No
- Bruise Easily:**  Yes  No
- Abnormal Bleeding:  Yes  No
- (with tooth extractions)
- Blood Thinning Medications  Yes  No

**Stomach/Intestinal Disorder**

- Ulcers:  Yes  No
- Bowel Disease  Yes  No
- Blood in stool:  Yes  No
- Black stools:  Yes  No
- Vomiting blood:  Yes  No

**Allergies:**

- Sinus infections:  Yes  No
- Hay Fever:  Yes  No
- Hives or skin rashes:  Yes  No
- Environmental reactions:  Yes  No

**AGE:** \_\_\_\_\_

**CNS Disorder:**

- Fainting spells:  Yes  No
- Seizures:  Yes  No
- Epilepsy:  Yes  No
- Stroke:  Yes  No

**Infections:**

- Viral Illnesses:  Yes  No
- Strep Throat:  Yes  No
- HIV:  Yes  No
- Viral Hepatitis:  Yes  No
- Sexually Transmitted Dz:  Yes  No

**Endocrine Disorder:**

- Diabetes:  Yes  No

**Autoimmune Disorder:**

- Rheumatoid Arthritis:  Yes  No
- Lupus  Yes  No

**Bone/Muscle Disorder:**

- Osteoarthritis:  Yes  No
- Artificial Joints:  Yes  No

**7. Family History:** Have you or anyone in your family ever had:

- Skin Cancer  Yes  No
- Oral Cancer  Yes  No
- Malignant Hypothermia  Yes  No
- Reaction to General Anesthesia  Yes  No
- Bleeding Disorder  Yes  No

**8. Comment on Yes answers and list any diseases, illnesses, or health problems not covered above:** \_\_\_\_\_  
\_\_\_\_\_

**9. Please list any prescription or over the counter medications you are taking including herbal remedies:** \_\_\_\_\_  
\_\_\_\_\_

**10. Have you ever taken: (circle)**

Accutane	Phen-Fen	Redux
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**11. Please list the frequency and length of time you have used any of the following:**

- Cigarettes:** Pk/Day \_\_\_\_\_ # Years \_\_\_\_\_
- Chewing Tobacco:** Cans/wk \_\_\_\_\_ # Years \_\_\_\_\_
- Alcohol:** Amt: \_\_\_\_\_ # Years \_\_\_\_\_
- IV/Illegal Drugs:** Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_

**12. Drug Allergies/Reactions:**

- Aspirin:  Yes  No
- Codeine:  Yes  No
- Iodine:  Yes  No
- Local Anesthetic:  Yes  No
- Pain Medications:  Yes  No
- Penicillin  Yes  No
- Sulfa Drugs:  Yes  No
- Steroids:  Yes  No
- Tranquilizers/Sedatives:  Yes  No
- Thyroid :  Yes  No
- Valium or Demerol:  Yes  No
- Latex  Yes  No

**13. Women: Do you take any kind of hormonal medications or oral contraceptives?**  Yes  No

**14. Women: Are you, or might you be pregnant?**  Yes  No

\_\_\_\_\_  
Patient Signature Date