**Confidential Health History**

Patient Name: Date of Birth:

1. **CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question)
   1. Yes / No Is your general health good?

If NO, explain:

* 1. Yes / No Has there been a change in your health within the last year?

If YES, explain:

* 1. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

If YES, explain:

* 1. Yes / No Are you being treated by a physician now? If YES, explain: Date of last medical exam? Reason for exam:
  2. Yes / No Have you had problems with prior dental treatment?

If YES, explain: Date of last dental exam: Name of last treating dentist:

* 1. Yes / No Are you in pain now?

If YES, explain:

1. **HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

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

Other:

1. **HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please circle Yes or No for each) Yes / No Heart disease Yes / No AIDS/HIV Yes / No Psychiatric care

Yes / No Family history of heart disease Yes / No Surgeries Yes / No Osteoporosis Yes / No Heart attack Yes / No Hospitalization Yes / No Thyroid disease Yes / No Artificial joint Yes / No Diabetes Yes / No Asthma

Yes / No Stomach problems or ulcers Yes / No Family history of diabetes Yes / No Hepatitis

Yes / No Heart defects Yes / No Tumors or cancer Yes / No Sexual transmitted disease Yes / No Heart murmurs Yes / No Chemotherapy Yes / No Herpes

Yes / No Rheumatic fever Yes / No Radiation Yes / No Canker or cold sores Yes / No Skin disease Yes / No Arthritis, rheumatism Yes / No Anemia

Yes / No Hardening of arteries Yes / No Emphysema or other lung disease Yes / No Liver disease Yes / No High blood pressure Yes / No Kidney or bladder disease Yes / No Eye disease Yes / No Seizures Yes / No Stroke Yes / No Transplants Yes / No Cosmetic surgery Yes / No Eating disorders Yes / No Tuberculosis

Other:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**  (Please circle Yes or No for each) | | | | | | |
| Yes / No Aspirin | | Yes / No | Valium or other sedatives | Yes / No | Codeine or other narcotics | |
| Yes / No Penicillin or other antibiotics | | Yes / No | Latex | Yes / No | Food | |
| Yes / No Nitrous oxide | | Yes / No | Local anesthetic | Yes / No | Metal | |
| Others: | |  |  |  |  | |
| **V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**  (Please circle Yes or No for each) | | | | | |  |
| Yes / No | Recreational drugs | Yes / No | Tobacco in any form | Yes / No | Antibiotics |  |
| Yes / No | Over-the-counter medicines | Yes / No | Alcohol | Yes / No | Supplements |  |
| Yes / No Yes / No | Weight loss medications Anti-Depressants | Yes / No Yes / No | Bisphosphonate (Fosamax) Herbal Supplements | Yes / No | Aspirin |  |
| Please list all prescription medications: | | | | | | |

1. **WOMEN ONLY** (Please circle Yes or No for each) Yes / No Are you or could you be pregnant? If YES, what month? Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

1. **ALL PATIENTS** (Please circle Yes or No for each) Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain:

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:

Yes / No Have you ever taken Fen-Phen? If YES, when: Yes / No **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.*

Patient’s Signature: Date:

Physician’s Name: Phone Number:

## Whom would you like us to contact in case of an emergency?

**Name**:

**Relationship**:

**Phone Number**:

## 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

**MEDICAL UPDATES**

# I have reviewed my Health History and confirm that it accurately states past and present conditions.

DENTIST DATE PATIENT SIGNATURE CHANGES TO HEALTH HISTORY INITIALS

(AS 10/2014)