Confidential Health History Form

Today's Date _____

Patient's Name: First _____ MI ____ Last _____ **Date of Birth** _____

I. **Check appropriate answer** (Leave blank if you do not understand the question)

1. ☐ Yes ☐ No Is your general health good?

   If NO, explain _____

2. ☐ Yes ☐ No Has there been a change in your health within the last year?

   If YES, explain _____

3. ☐ Yes ☐ No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?

   If YES, explain _____

4. ☐ Yes ☐ No Are you being treated by a physician now?

   If YES, explain _____

5. ☐ Yes ☐ No Are you in pain now?

   If YES, explain _____

II. **Have you experienced any of the following?** (Please check Yes or No for each)

☐ Yes	☐ No	Chest pain (angina)	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No	Frequent vomiting
☐ Yes	☐ No	Fainting spells	☐ Yes	☐ No	Blood in stools	☐ 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	Diarrhea or constipation	☐ Yes	☐ No	Bruise easily	☐ Yes	☐ No	Sinus problems

III. **Have you had or do you have any of the following**? (Please check Yes or No for each)

☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Cosmetic surgery	☐ Yes	☐ No	Eating disorders
☐ 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	Tuberculosis

This information will not be released unless specifically authorized by patient.

☐ Yes ☐ No AIDS/HIV ☐ Yes ☐ No Anxiety ☐ Yes ☐ No Depression ☐ Yes ☐ No Treatment for emotional condition

IV. **Are you allergic to or have you had a reaction to any of the following?** (Please check Yes or No for each)

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Valium	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Darvon	☐ Yes	☐ No	Demerol	☐ Yes	☐ No	Vicodin
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Percodan
☐ Yes	☐ No	Latex	☐ Yes	☐ No	Food	☐ Yes	☐ No	Nitrous oxide
☐ Yes	☐ No	Local anesthetic (Novocaine or Xylocaine)	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Metal

Others _____

V. **Are you taking or have you taken any of the following in the last three months?** (Please check 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	Weight loss medications	☐ Yes	☐ No	Bisphosphonate (Fosamax)	☐ Yes	☐ No	Aspirin
☐ Yes	☐ No	Cortico - Steroids						

Please list all medications you are currently taking _____

_____

VI. **Women only** (Please check 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?**

VII. **All patients** (Please check 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, 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 of 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 _____ Physician's 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 changes in my health and/or medication. Further, I will not hold my dentist, or any other member of his 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.

Date	Patient Signature	Changes to Health History	Dentist's Initials