

# PATIENT HEALTH HISTORY

PATIENT'S NAME (print) \_\_\_\_\_ DATE \_\_\_\_\_

## DENTAL HISTORY

- Do you have a specific dental problem? Describe: \_\_\_\_\_  YES  NO
- Do you have dental examinations on a routine basis? Last visit: \_\_\_\_\_  YES  NO
- Do you brush and floss on a routine basis? \_\_\_\_\_  YES  NO
- Do you want to keep your remaining teeth? \_\_\_\_\_  YES  NO
- Do you think you have active decay or gum disease? \_\_\_\_\_  YES  NO
- Do your gums routinely bleed? \_\_\_\_\_  YES  NO
- Do you feel nervous about having dental treatment? \_\_\_\_\_  YES  NO
- Have you ever had a bad experience in a dental office? \_\_\_\_\_  YES  NO
- Do you ever grind or clench your teeth? \_\_\_\_\_  YES  NO
- Do you ever have clicking, popping or discomfort in the jaw joints? \_\_\_\_\_  YES  NO
- Name of previous dentist: \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

## MEDICAL HISTORY

- Medical doctor's name: \_\_\_\_\_
- Are you under a physician's care now? Why? \_\_\_\_\_  YES  NO
- Have you ever been hospitalized? Why? \_\_\_\_\_  YES  NO
- Are you taking any drugs or medications now? Explain: \_\_\_\_\_  YES  NO
- Are you allergic to any medications or substances? Explain (Penicillin, codeine, latex rubber, etc.): \_\_\_\_\_  YES  NO

WOMEN: Are you pregnant? Due date: \_\_\_\_\_  YES  NO

Check any of the following which you have had or now have:

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Hay fever        | <input type="checkbox"/> Chemotherapy          |
| <input type="checkbox"/> Congenital heart lesion | <input type="checkbox"/> Yellow jaundice     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Nickel allergy   | <input type="checkbox"/> Radiation treatment   |
| <input type="checkbox"/> Heart pacemaker         | <input type="checkbox"/> Blood disease       | <input type="checkbox"/> Excessive thirst    | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> AIDS (HIV)            |
| <input type="checkbox"/> Mitral valve prolapse   | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Positive HIV test     |
| <input type="checkbox"/> Heart surgery           | <input type="checkbox"/> Bruise easily       | <input type="checkbox"/> Lung disease        | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Alzheimer's disease   |
| <input type="checkbox"/> Artificial heart valve  | <input type="checkbox"/> Blood transfusion   | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Arthritis/Gout   | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Surgical implants       | <input type="checkbox"/> Joint replacement   | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Rheumatism       | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Drug addiction        |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Low Blood pressure  | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Night sweats          |

Have you had or now have any other diseases or conditions not listed above? \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

- Adult Patient  Father (or husband)  Mother (or wife)  Guardian  Other

REVIEWED BY \_\_\_\_\_ DATE \_\_\_\_\_

## MEDICAL UPDATES

I have read my MEDICAL HISTORY DATED \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	<input type="checkbox"/> NONE _____	_____
_____	_____	<input type="checkbox"/> NONE _____	_____
_____	_____	<input type="checkbox"/> NONE _____	_____
_____	_____	<input type="checkbox"/> NONE _____	_____
_____	_____	<input type="checkbox"/> NONE _____	_____