**Confidential Health History**

Patient Name: Date of Birth:

**I. CIRCLE 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 three years?

If YES, explain: \_\_\_\_\_\_\_\_

4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_\_\_\_

Date of last medical exam? Reason for exam: \_\_\_\_\_\_\_\_

5. Yes / No Have you had problems with prior dental treatment?

If YES, explain: \_\_\_\_\_\_\_\_

Date of last dental exam: Name of last treating dentist:

6. Yes / No Are you in pain now?

If YES, explain: \_\_\_\_\_\_\_\_

**II. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. 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 Weight loss medications

Yes / No Bisphosphonate (Fosamax)

Yes / No Aspirin

Yes / No Anti-Depressants

Yes / No Herbal Supplements

**Please list all prescription medications:**

**VI. 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?

**VII. 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\_\_\_\_\_\_\_\_\_\_