HEALTH HISTORY Name_____

I. Check Appropriate Answers: (Leave blank if you do not understand the question)

Yes No

☐ ☐ 1. Is your general health good? _____

☐ ☐ 2. Has there been a change in your health within the last year? _____

☐ ☐ 3. Have you been hospitalized or had a serious illness in the last three years? _____
Please explain_____

☐ ☐ 4. Are you being treated by a Physician now? _____
Please explain_____
Date of last general exam ____/_____/_____Date of last Dental exam____/____/____

5. If yes to 4 above, name of **Medical Doctor**_____
Phone Number (_____)_____

☐ ☐ 6. Have you had problems with prior dental treatment?
Please explain_____

☐ ☐ 7. Are you in pain now? Explain_____

II. Have You Experienced?

Yes	No			Yes	No		
☐	☐	8.	Chest pain (angina)?	☐	☐	19.	Dizziness?
☐	☐	9.	Swollen ankles	☐	☐	20.	Ringing in the ears?
☐	☐	10.	Shortness of breath?	☐	☐	21.	Headaches?
☐	☐	11.	Recent weight loss, fever, night sweat?	☐	☐	22.	Fainting spells?
☐	☐	12.	Persistent cough, coughing up blood?	☐	☐	23.	Blurred vision?
☐	☐	13.	Bleeding problems, bruising easily?	☐	☐	24.	Seizures?
☐	☐	14.	Sinus problems?	☐	☐	25.	Excessive thirst?
☐	☐	15.	Difficulty swallowing?	☐	☐	26.	Frequent urination?
☐	☐	16.	Diarrhea, constipation, blood in stools?	☐	☐	27.	Dry mouth?
☐	☐	17.	Frequent vomiting, nausea?	☐	☐	28.	Jaundice?
☐	☐	18.	Difficulty urinating, blood in urine?	☐	☐	29.	Joint pain, stiffness?

III. Do you Have Or Have You Had:

Yes	No			Yes	No		
☐	☐	30.	Heart disease? Explain_____	☐	☐	41.	AIDS or ARC?
☐	☐	31.	Heart attack? Explain_____	☐	☐	42.	HIV positive
☐	☐	32.	Heart murmur?	☐	☐	43.	VD (syphilis or gonorrhea)?
☐	☐	33.	High Blood pressure?	☐	☐	44.	Herpes?
☐	☐	34.	Stroke, hardening of arteries?	☐	☐	45.	Skin diseases?
☐	☐	35.	Rheumatic fever?	☐	☐	46.	Eye disease?
☐	☐	36.	TB, emphysema, other lung diseases?	☐	☐	47.	Anemia
☐	☐	37.	Hepatitis, other liver disease?	☐	☐	48.	Arthritis, rheumatism?
☐	☐	38.	Stomach problems, ulcers?	☐	☐	49.	Kidney, bladder disease?
☐	☐	39.	Allergies to: drugs, food, medications? _____	☐	☐	50.	Thyroid, adrenal disease?
☐	☐	40.	Family history of diabetes, heart problems, tumors?	☐	☐	51.	Diabetes?

IV. Do You Have Or Have You Had:

Yes	No		
☐	☐	52.	Tumors, cancer?
☐	☐	53.	Radiation treatments?
☐	☐	54.	Chemotherapy?
☐	☐	55.	Prosthetic heart valve?
☐	☐	56.	Latex Allergy?
☐	☐	57.	Artificial joint?
☐	☐	58.	Contact lenses?
☐	☐	59.	Have you taken phen-phen or diet pills
☐	☐	60.	Blood transfusions?
☐	☐	61.	Surgeries?
☐	☐	62.	Pacemaker?
☐	☐	63.	Psychiatric care?

V. Are You Taking:

Yes	No		
☐	☐	64.	Have you ever taken any cancer medications containing bisphosphonates? (Fosamax, Boniva, Actonel)
☐	☐	65.	Recreational drugs? (Addiction)
☐	☐	66.	Tobacco in any form?
☐	☐	67.	**Medications** (including Aspirin)?

Please list_____

_____

_____

Yes	No		
☐	☐	68.	Are you or could you be pregnant or nursing?
☐	☐	69.	Taking birth control pills?

VII. All Patients:

Yes No

☐ ☐ 70. Do you have had any other diseases or medical problems NOT listed on this form?
Please explain_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Blue House Dentistry of any change/changes in my health and or medication.

Date____/____/_____Patient's Signature_____Doctor_____

RECALL REVIEW

1. Date____/____/____Medical Changes_____ Patient's Signature_____Doctor_____
2. Date____/____/____Medical Changes_____ Patient's Signature_____Doctor_____
3. Date____/____/____Medical Changes_____ Patient's Signature_____Doctor_____