HEALTH HISTORY

Date_____

Name_____ Date of Birth_____ Last Dental Visit _____

Physicians Name_____ Phone Number_____

Please answer each question. Check yes or no. If in doubt leave blank.	Yes	No
Are you now under the care of a physician?.....		
If so, what is the condiditon for which you are being treated?.....		
Have you ever been hospitalized or had a serious illness?.....		
If yes, explain_____		
Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?.....		
(Women) Are you pregnant? If so, give due date.....		
Do you use tobacco in any form? If yes, how much.....		

Please circle any of the following that apply to you.

General
Tire easily, weakness
Marked weight change
Night sweats
Persistent fever

Skin
Eruptions (rash) hives
Change in skin color

Eyes
Visual Change
Glaucoma

Ears
Loss of hearing
Ringing in ears

Nose
Frequent nosebleeds
Sinus problems

Throat
Soreness/hoarseness

Nervous System
Stroke
Headaches
Convulsions/epilepsy
Numbness/tingling
Dizziness/fainting
Psychiatric treatment

Respiratory
Tuberculosis
Emphysema
Asthma/hay fever
Persistent cough
Difficulty breathing while lying down

Endocrine
Diabetes
Family history of diabetes
Thyroid condition/goiter
Other

Heart/Blood Vessels
Rheumatic fever
Heart murmur
Chest pain/discomfort
Heart attack/trouble
Shortness of breath
Swelling of ankles
High blood pressure
Congenital heart disease
Artificial heart valve
Pacemaker
Heart surgery
Mitral Valve Prolapse
Other

Bone/muscles
Arthritis/rheumatism
Artificial joints

Digestive System
Hepatitis
Jaundice
Ulcers
Change in appetite

Urinary
Kidney disease
Increase in frequency of urination
Venereal Disease

Blood
Bruise easily
Anemia
Blood transfusion
Excessive bleeding

Other
Radiation therapy
Tumors or growths
Cancer
AIDS or HIV

Are you allergic or have you ever experienced any reaction to the following?
Local anesthetics (Novocaine, etc.)
Barbituates/sedatives/sleeping pills
Penicillin/other antibiotics
Aspirin or codeine
Sulfa drugs
Other allergies_____

Are you taking any of the following?
Antibiotics,/sulfa drugs
Blood thinners
Blood pressure medication
Thyroid medicine
Cortisone/steroids
Antihistamines/allergy drugs
Tranquilizers
Insulin/other diabetes drugs
Recreational drugs
Digitalis/other heart medications
Nitroglycerin
Aspirin
Birth control pills

Please list your medications

_____
_____
_____
_____
_____
_____

Why are you seeking care?
Routine exam & cleaning
Broken tooth/lost filling
Pain
New dentures or partial
TMJ problem
Bleaching
Other