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Confidential Health History

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Check Appropriate Answer:

Is your general health good? * ◯ Yes ◯ No

If NO, please explain:

_____

_____

Have there been any changes in your health within the last year? * ◯ Yes ◯ No

If YES, please explain:

_____

_____

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

If YES, please explain:

_____

_____

Are you being treated by a physician now? * ◯ Yes ◯ No

If YES, please explain:

_____

_____

What was the date of your last medical exam? _____

What was the reason for your medical exam? _____

Have you had problems with prior dental treatment? * ◯ Yes ◯ No

If YES, please explain:

_____

_____

What was the date of your last dental exam? _____

What is the name of your last treating dentist? _____

Are you in pain now? ◯ Yes ◯ No

If YES, please explain: _____

Have you ever experienced any of the following?

Please mark all that apply. Leave blank if you are not sure. *

- ☐ Fainting spells
- ☐ Recent significant weight loss
- ☐ Night sweats
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Bleeding problems
- ☐ Blood in urine
- ☐ Blood in stools
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Bruise easily
- ☐ Frequent vomiting
- ☐ Jaundice
- ☐ Dry mouth
- ☐ Excessive thirst
- ☐ Difficulty swallowing
- ☐ Swollen ankles
- ☐ Joint pain or stiffness
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Other

Have you ever had or do you have any of the following?

Please mark all that apply. Leave blank if you are not sure. *

- ☐ Heart disease
- ☐ Family history of heart disease
- ☐ Heart attack
- ☐ Heart defects
- ☐ Heart murmurs
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Rheumatic fever
- ☐ Artificial joints (hip, knee, etc)
- ☐ Stomach problems or ulcers
- ☐ Skin disease
- ☐ Seizures
- ☐ AIDS/HIV
- ☐ Surgeries
- ☐ Hospitalization
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Family history of diabetes
- ☐ Tumors or cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Arthritis, rheumatism
- ☐ Emphysema or other lung disease
- ☐ Kidney or bladder disease
- ☐ Eating disorders
- ☐ Pyschiatric care
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Hepatitis
- ☐ Sexually transmitted disease
- ☐ Herpes
- ☐ Canker or cold sores
- ☐ Anemia
- ☐ Liver disease
- ☐ Eye disease
- ☐ Transplants
- ☐ Tuberculosis
- ☐ Other

Are you ALLERGIC to or have you had a reaction to any of the following?

Please mark all that apply. Leave blank if you are not sure. *

- ☐ Aspirin
- ☐ Penicillin or other antibiotics - please list below
- ☐ Nitrous Oxide
- ☐ Metal
- ☐ Valium or Sedatives
- ☐ Latex
- ☐ Codeine or other opioids
- ☐ Local Anesthetic
- ☐ Dairy/ Lactose Intolerant
- ☐ Other

If other, please explain:

Are you taking or have you taken any of the following in the last 3 months?

Please mark all that apply. Leave blank if you are not sure. *

- ☐ Recreational drugs
- ☐ Over-the-counter medicines
- ☐ Weight loss medications
- ☐ Anti-depressants
- ☐ Opioids (Ex: Norco, Vicodin, Percocet, Percodan)
- ☐ Tobacco in any form
- ☐ Alcohol
- ☐ Bisphosphonate (Ex: Fosamax, Boniva, Alendronate)
- ☐ Herbal supplements
- ☐ Antibiotics
- ☐ Supplements
- ☐ Aspirin
- ☐ Other

Are you on any other medications not listed above? Please add them here:

Do you have or have you had any other diseases or medical problems NOT listed on this form? * ◯ Yes ◯ No

If YES, please explain:

_____

_____

Have you ever pre-medicated for dental treatment? ◯ Yes ◯ No

If YES, why: _____

Have you ever taken Fen-Phen? ◯ Yes ◯ No

If YES, when: _____

Is there any issue or condition that you would like to discuss with the dentist in private? ◯ Yes ◯ No

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Women Only

Are you or could you be pregnant? ◯ Yes ◯ No

If YES, what month are you due? _____

Are you nursing? ◯ Yes ◯ No

Are you taking birth control pills? ◯ Yes ◯ No

☐ ***I acknowledge that 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.**

Signature _____ **Date** _____

Physician's Name and Phone Number:

_____

_____

Whom would you like us to contact in case of an emergency? * _____

Relationship of your emergency contact: _____

Emergency contact's phone number: _____

☐ ***I certify that I have read and undersatnd 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 team, responsible for any errors or omissions that I may have made in the completion of this form.**

Signature _____ **Date** _____

Response Date: _____