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 HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Chest Pain (angina)	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Bleeding problems	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemo/Radiation	Herpes
Rheumatic fever	Dry mouth	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders/Weight loss	Tuberculosis

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: ______________________________

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list all other medications you are currently taking: ______________________________

____

____

____

____

____

____

V. WOMEN ONLY

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?

VI. ALL PATIENTS

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: ____________________

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 Signature of Dentist Date

…………………………………………………………………………………………

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________
________	________________	________________	________