

HEALTH HISTORY

Patient Name _____

In order to get to know you better, we would like for you to tell us as much as you can about your previous medical history, including any illnesses, injuries, surgical procedures, diagnoses or problems that you can share with us. Also include anything that you may be concerned about, whether you have shared it with your physician yet or not.

Name & Address of your physician (medical doctor): _____

- 1. Date of last medical exam _____
- 2. Currently under care? _____
- 3. Recent illness or operation? _____
- 4. Hospitalized for major surgery or mental health? _____

<p>Does your physician require you to be pre-medicated for dental appointments? Yes No If so what do you usually take?</p> <p>Do you have any implants?</p>
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HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?: Please Circle

- 1. Abnormal Heart condition, heart attack, angina, chest pain
- 2. Anemia or other blood disorders or high cholesterol
- 3. Abnormal bleeding from a cut, bruise easily, hemophilia
- 4. Diabetes(blood sugar), frequent urination or thirst, or hypoglycemia
- 5. Rheumatic fever, heart murmur or rheumatic heart disease, mitral valve prolapse, artificial heart valves, or pacemaker
- 6. Arthritis, rheumatism, Lupus, autoimmune problems, bone disease, artificial joints, or limbs
- 7. Kidney problems, dialysis, IV shunts
- 8. Epilepsy, convulsions, seizures or fainting, strokes
- 9. High or low blood pressure, swollen ankles, retained water
- 10. Lung disease, bronchitis, TB, cough, emphysema, asthma—DO YOU SMOKE? Yes No How much?
- 11. Cancer, Tumors, radiation or chemotherapy
- 12. Eye, ear, nose, throat or sinus problems
- 13. Sudden weight loss or gain, thyroid problems, anorexia, bulimia
- 14. Skin disease, hives, allergies, rashes, pollen, hay fever
- 15. Nervous disorders, fainting, dizziness
- 16. Mental disorders, psychotherapy, counseling
- 17. Are you under excessive tension, pressure or stress?
- 18. Frequent headaches, neck aches, back or shoulder problems, Fibromyalgia?
- 19. Hepatitis A, B or C, jaundice, liver disease or cirrhosis
- 20. AIDS, HIV, Syphilis, Gonorrhea, Herpes, VD
- 21. Describe any kind of pain you may be experiencing and rate on a 1-10 scale:

ARE YOU TAKING OR HAVE YOU BEEN TAKING:

- 1. Cortisone/Steroids, ACTH, anti-reaction drugs
- 2. Anti-coagulants, Coumadin, Warfarin, Heparin, Aspirin, NSAIDS
- 3. Tranquilizers, sedatives, uppers, downers or pain drugs
- 4. Any other medicine or drugs. Please list here:

HAVE YOU EVER HAD A REACTION OR ALLERGY TO:

- 1. Penicillin, or other antibiotics or pain medications
- 2. Local anesthetics (Novocaine, Xylocaine, Lidocaine, Carbocaine, Articaine)
- 3. Nickel (metal zippers, snaps, etc.), gold, other metals or plastics or LATEX?
- 4. Do you have any disease problem or condition not listed above?
- 5. Have you ever experienced any unfavorable reaction or result from previous medical or dental treatment?

WOMEN ONLY:

- 1. Are you pregnant?.....Due Date?
- 2. Do you have painful or irregular menses (periods)?
- 3. Have you ever undergone menopause?
- 4. Do you use birth control pills, hormones, etc.?

PATIENT(or Guardian) SIGNATURE _____ DATE _____

History taken by _____