PATIENT HEALTH HISTORY

Name: First, Middle, Last | Sex | Birth Date | Marital Status

Home/Work/Cell/e-mail
preferred contact | cell phone | Email address

MEDICAL HISTORY

Medical Doctor's Name | Address | Phone

Date of My Last Physical Examination | Results

Are you being treated by a medical doctor now? If yes, for what reason?

Are you taking any medication at the present time? If yes, what?

Are you sensitive or allergic to any medicine(including non-prescription medications)? If yes, what?

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates.

Have you ever had any blood transfusions? If yes, give reason.

Have you ever had to pre-medicate prior to any Dental or Medical treatment? If yes, give reason

Have you had or are you:

- Yes •No HIV Positive
- Yes •No Gall Bladder Disease
- Yes •No Low Blood Pressure
- Yes •No Asthma
- Yes •No Nervousness
- Yes •No Anemia
- Yes •No Tuberculosis
- Yes •No Fainting or Dizzy Spells
- Yes •No Ulcers (Stomach or Intestinal)
- Yes •No Scarlet Fever
- Yes •No Thyroid Disease (or Goiter)
- Yes •No Venereal Disease (Syphilis or Gonorrhea)
- Yes •No Psychiatric Treatment
- Yes •No Kidney Disease
- Yes •No High Blood Pressure
- Yes •No AIDS
- Yes •No Diabetes (Sugar Disease)
- Yes •No Stroke
- Yes •No Hay Fever
- Yes •No Epilepsy or Seizures
- Yes •No Allergies or Hives
- Yes •No Rheumatic Fever
- Yes •No Pacemaker
- Yes •No Arthritis
- Yes •No Heart Murmur
- Yes •No X-Ray or Cobalt Treatment
- Yes •No Heart Disease
- Yes •No Angina Pectoris
- Yes •No Chemotherapy (Cancer, Leukemia)

• Yes •No Hepatitis
• Yes •No Bladder Disease
• Yes •No COPD
• Yes •No Cognitive Impairment
• Yes •No Osteoporosis or Osteopenia
• Yes •No Pneumonia
• Yes •No Obesity
• Yes •No Metabolic Syndrome• Yes •No Do you have pain in the chest upon exertion?
• Yes •No Do you have shortness of breath after mild exercise?
• Yes •No Do you use extra pillows to sleep?
• Yes •No Do your ankles swell?
• Yes •No Do you bruise easily?
• Yes •No Have you ever had yellow jaundice?
• Yes •No Do you have to urinate (pass water) more than 6 times a day?
• Yes •No Are you thirsty much of the time?
• Yes •No Does your mouth frequently become dry?
• Yes •No Have you lost or gained weight (more than 10 lbs.) in the past year?
• Yes •No Are you following a diet?
• Yes •No Do you have cataracts or glaucoma?
• Yes •No Do you have difficulty swallowing?
• Yes •No Has a doctor ever said you have cancer or a tumor?
• Yes •No Have you ever had excessive bleeding from a cut or wound?
• Yes •No Do you have frequent severe headaches?
• Yes •No Do you worry a great deal?
• Yes •No Are you under abnormal stress? (e.g., marital, business, or social)
• Yes •No Do you feel you need psychiatric care or advice?
• Yes •No Do you sometimes take medicine to relieve anxiety?

Do you have any disease, condition, or problem not listed above?

If yes, explain: ____

Females
• Yes •No Do you have trouble with your periods? (if you do not menstruate, answer no)
• Yes •No Did you have any complications during pregnancy (if you have never been pregnant, answer no)
• Yes •No Are you pregnant? (date of delivery ________________________________)
• Yes •No Are you taking oral contraceptives (birth control pills)?

Dental History
• Yes •No Have you had any serious trouble associated with any previous dental treatment?
If yes, explain: ____
• Yes •No Do you bleed excessively after tooth extraction?
• Yes •No Have you recently had dental x-rays? If yes, when:____________________________________
• Yes •No Have you had undesirable reactions to local or general anesthetics (e.g., Novocain or gas)?
• Yes •No Do you clench or grind your teeth?
• Yes •No Are any of your teeth sensitive to cold or sweets?
• Yes •No Are you dissatisfied with the appearance of your teeth?
• Yes •No Have you had excessive swelling or pain after oral surgery?
• Yes •No Have your teeth been cleaned recently?
• Yes •No Do you have bleeding gums?
• Yes •No Do you have a bad taste in your mouth?
• Yes •No Does food pack between your teeth?
• Yes •No Does your jaw click or pop when you chew?
• Yes •No Have you ever received treatment for periodontal disease?
• Yes •No Has a dentist ever ground your teeth to correct your bite?

• Yes •No **Are you willing to become actively involved in the treatment of your periodontal disease?**

Briefly state your feelings toward crowns, fixed bridges or removable Full/Partial dentures:

____

____

What is your chief complaint concerning your mouth or teeth? ______________________________

____

To the best of my knowledge, all of the above answers are true and correct. If I have any change in my health, I will inform Dr. ________________________________ at my next appointment.

____ ______________________________
Signature of Patient Date