HEALTH HISTORY

Today's date ____/____/____ **PLEASE PRINT**

PATIENT'S NAME	SEX	AGE	BIRTHDATE	SOC SEC #	HOME TEL.: WORK/CELL:
RESPONSIBLE PARTY'S NAME (Policy Holder)	SEX	AGE	BIRTHDATE	SOC SEC #	CIRCLE ONE: **S M D W** SPOUSE'S NAME:
HOME ADDRESS: CITY, STATE, ZIP	EMPLOYER (COMPANY NAME AND TEL. #)				REFERRING DENTIST'S NAME AND TELEPHONE
NAME AND TELEPHONE # OF RELATIVE (NOT AT SAME ADDRESS):			RELATIVE'S ADDRESS:		
FAMILY PHYSICIAN'S NAME AND TELEPHONE:	ORTHODONTIST'S NAME AND TELEPHONE #:				FAMILY MEMBERS WHO HAVE BEEN PATIENT'S HERE:
REASON FOR VISIT HERE:	**EMAIL:**				

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) ALL RESPONSES ARE KEPT CONFIDENTIAL

2. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? ..... Y N
3. DATE OF LAST PHYSICAL EXAM? _____
4. ARE YOU NOW UNDER A PHYSICIAN'S CARE FOR A PARTICULAR PROBLEM? ..... Y N
5. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATIONS? IF SO, DESCRIBE ..... Y N

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6. HAVE YOU HAD ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? .. Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE? ..... Y N
B. CONGENITAL HEART DISEASE? ..... Y N
C. CARDIOVASCULAR DISEASE (HEART TROUBLE, HEART ATTACK, HEART MURMER, CORONARY ARTERY DISEASE, ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)? ..... Y N
D. LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING)? ..... Y N
E. SEIZURES, CONVULSIONS, EPILEPSY, SEIZURES, FAINTING, PSYCHIATRIC TREATMENT, DIZZINESS, NERVOUS DISORDER OR BREAKDOWN? .. Y N
F. BLEEDING DISORDER, ANEMIA BLEEDING TENDENCY, BLOOD TRANSFUSION, DO YOU BRUISE EASILY? ..... Y N
G. LIVER DISEASE (JAUNDICE, HEPATITIS)? ..... Y N
H. KIDNEY DISEASE? ..... Y N
I. DIABETES? ..... Y N
J. THYROID DISEASE (GOITER)? ..... Y N
K. ARTHRITIS? ..... Y N
L. STOMACH ULCERS OR COLITIS? ..... Y N
M. GLAUCOMA? ..... Y N
N. FREQUENT OR RECURRING MOUTH SORES? ..... Y N
O. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE, HIP, KNEE)? ..... Y N
P. RADIATION (X-RAY) TREATMENT FOR CANCER? ..... Y N
Q. CLICKING OR POPPING OF JAW POINT, PAIN NEAR EAR, DIFFICULTY OPENNING MOUTH, GRIND OR CLENCH TEETH? . Y N
R. SINUS OR NASAL PROBLEMS? ..... Y N
S. ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? ..... Y N
T. RECURRENT INFECTIONS OF ANY KIND? ..... Y N

8. ARE YOU USING OR TAKING ANY OF THE FOLLOWING?

A. TAGAMET? ..... Y N
B. THYROID MEDICATIONS? ..... Y N
D. ANTICOAGULANTS (BLOOD THINNERS)? ..... Y N
E. HIGH BLOOD PRESSURE MEDICINE? ..... Y N
F. STEROIDS (CORTISONE, ETC)? ..... Y N
G. TRANQUILIZERS (VALIUM, ETC)? ..... Y N
H. INSULIN, DIABENESE, OR SIMILAR DRUG? ..... Y N
I. DIGITALIS, INDERAL, NITROGLYCERIN, CALCIUM CHANNEL BLOCKERS, PROCARDIA OR OTHER HEART MEDICINE? ..... Y N
J. ASPIRIN OR IBUPROFEN (MOTRIN, NAPROSYN, ETC.)? ..... Y N
HOW MUCH DAILY? _____
K. MARIJUANA OR OTHER "STREET" DRUGS? ..... Y N
L. ANTIHISTAMINES OR DECONGESTANTS (SELDANE)? ..... Y N
M. ARE YOU TAKING ANY OTHER REGUALR MEDICATIONS, PILLS, OR DRUGS? ..... Y N
IF YES, PLEASE LIST: _____

9. ARE YOU ALLERGIC OR HAD BAD REACION TO:

A. LOCAL ANESTHETIC (NOVOCAINE, ETC.)? ..... Y N
B. PENICILLIN, AMOXICILLIN, CEPHALOSPORINS OR OTHER ANTIBIOTICS? ..... Y N
C. BARBITURATES, SEDATIVES, ETC.? ..... Y N
D. ASPIRIN OR IBUPROFEN? ..... Y N
E. CODEINE OR OTHER PAIN KILLERS? ..... Y N
F. LATEX OR RUBBER PRODUCTS? ..... Y N
G. OTHER ALLERGIES OR REACTIONS? ..... Y N
IF YES, PLEASE LIST: _____

10. DO YOU SMOKE OR CHEW TOBACCO? ..... Y N
11. DO YO USE ALCOHOL? ..... Y N

12. FOR WOMEN ONLY:

A. IF YOU ARE USING ORAL CONTRACEPTIVES IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH EFFECTIVENESS OF ORAL CONTRACEPTIVES. THEREFORE, YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATIONS IS COMPLETED. PLEASE CONSULT WITH YOUR PHYSICIAN FOR FURTHER GUIDANCE.
B. IF YOU ARE PREGNANT, POSSIBLY PREGNANT OR TRYING TO BECOME PREGNANT, SURGERY, ANESTHETICS OR ANY OTHER MEDICATION MAY SIGNIFICANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING THE FIRST TRIMISTER. PLEASE ADVICE YOU DOCTOR IF THERE IS ANY CHANCE OF YOUR BEING PREGNANT!
C. DO YOU WISH TO HAVE A PREGNANCY TEST? ..... Y N

13. DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? ..... Y N
14. DO YOU WISH TO TALK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING? ..... Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ /_____
SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DOCTOR'S INITIALS

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED ____/____/____ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

DATE	EXCEPTIONS OR CHANGES	PATIENT'S SIGNATURE	DOCTOR'S INITIALS
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