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 **Health History**

**Section 1. Patient Information**

First Name Last Name Patient ID Date of Birth *(month/day/year)* Sex

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**Section 2. Circle appropriate answer**

YES NO Questions (*leave blank if you do not understand question*)

1. Is your general health good?
2. Has there been a change in your health within the last year?
3. Have you been hospitalized or had a serious illness in the last three years?

 If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you being treated by a physician now? For what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of last medical exam\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had problems with prior dental treatment?
2. Are you in pain now?

**Section 3. Have you experienced**

YES NO Questions YES NO Questions

1. Chest pain (angina)
2. Swollen ankles
3. Shortness of breath
4. Recent weight loss, fever, night sweats
5. Persistent cough, coughing up blood
6. Bleeding problems, bruising easily
7. Sinus Problem
8. Difficulty swallowing
9. Diarrhea, constipation, blood in stools
10. Frequent vomiting, nausea
11. Difficulty urinating, blood in urine
12. Dizziness
13. Ringing in ears
14. Headaches
15. Fainting spells
16. Blurred vision
17. Seizures
18. Excessive thirst
19. Frequent urination
20. Dry mouth
21. Jaundice
22. Joint pain, stiffness

**Section 4. Do you have or have you had**

YES NO Questions YES NO Questions

1. Heart disease
2. Heart attack, heart defects
3. Heart murmurs
4. Rheumatic fever
5. Stroke, hardening of arteries
6. High blood pressure
7. Asthma, TB, emphysema, other lung diseases
8. Hepatitis, other liver disease
9. Stomach problems, ulcers
10. Allergies to: foods, latex
11. Family history of diabetes, heart problems, tumors
12. AIDS
13. Tumors, cancer
14. Arthritis, rheumatism
15. Eye diseases
16. Skin diseases
17. Anemia
18. VD (syphilis or gonorrhea)
19. Herpes
20. Kidney, bladder disease
21. Thyroid, adrenal disease
22. Diabetes

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 **Health History**

**Section 5. Have you experienced**

YES NO Questions YES NO Questions

1. Psychiatric care
2. Radiation treatments
3. Chemotherapy
4. Prosthetic heart valve
5. Artificial joint
6. Hospitalization
7. Blood transfusions
8. Surgeries
9. Pacemaker
10. Contact lenses

**Section 6. Are you taking**

YES NO Questions YES NO Questions

61. Recreational drugs

62. Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?

63. Tobacco in any form

64. Alcohol. Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7. Women only**

 YES NO Questions YES NO Questions

65. Are you or could you be pregnant or nursing

 66. Taking birth control pills

**Section 7. All patients**

YES NO Questions

67. Do you have or have you had any other diseases or medical problems NOT listed on this form?

 *If yes, please explain below.*

68. Are you allergic to any medications (i.e. Aprin, Penicillin etc)? Please list them here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***To the best of my knowledge, I have answered every question completely and accurately.***

***I will inform my dentist of any changes in my health and/or medication.***

Patient’s Signature Date

(Or Legal Guardian if minor)

Recall Review:

1. Patient’s Signature Date
2. Patient’s Signature Date
3. Patient’s Signature Date

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