Health History Form

Correctly answering the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____Birth date_____ Age_____
Why are you now seeking dental treatment? _____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now? ..... YES NO
2. Are you under the care of a physician? ..... YES NO
   If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious illness? ..... YES NO
   If yes, please explain_____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... YES NO
5. (Women) Are you pregnant? If so, give due date _____ YES NO
6. Doyou use tobacco in any form? If yes, how much _____ YES NO
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... YES NO
8. Do you have or have you ever had any of the following? Please circle any that apply.

GENERAL
Marked weight change
Night sweats
Persistent fever

SKIN
Eruptions (rash) hives
Change in skin color

EYES
Visual change
Glaucoma

EARS
Loss of hearing
Ringing in ears

NOSE
Frequent nosebleeds
Sinus problems

THROAT
Soreness/hoarseness

BLOOD
Bruise easily
Anemia
Blood transfusion

BONE/MUSCLES
Arthritis/rheumatism
Artificial joints/limbs

HEART/BLOOD VESSELS
Rheumatic fever
Heart murmur
Chest pain/discomfort
Heart attack/trouble
Shortness of breath
Swelling of ankles
High blood pressure
Congenital heart disease
Mitral valve prolapse
Artificial heart valve
Pacemaker
Heart surgery
Other

RESPIRATORY
Tuberculosis
Emphysema
Asthma/hay fever
Persistent cough
Sputum production (phlegm)
Cough up bloody sputum
Difficulty breathing
while lying down

ENDOCRINE
Diabetes
Family history of diabetes
Thyroid condition/goiter
Other

DIGESTIVE SYSTEM
Hepatitis
Jaundice
Ulcers
Change in appetite
Black, bloody or pale stools

URINARY
Kidney disease
Increase in frequency
of urination(night)
Burning on urination
Urethral discharge
Bloody urine
Venereal disease

OTHER
Latex Sensitivity
Radiation therapy
Chemotherapy
Tumors or growths
Cancer
HIV+
AIDS

NERVOUS SYSTEM
Stroke
Headaches
Convulsions/epilepsy
Numbness/tingling
Dizziness/fainting
Psychiatric treatment