HEALTH HISTORY

Patient's Name: _____ Birth Date _____

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question)

1. Yes No IS PATIENT'S GENERAL HEALTH GOOD ?
2. Yes No HAS THERE BEEN A CHANGE IN PATIENT'S HEALTH WITHIN THE YEAR ?
3. Yes No HAS PATIENT BEEN HOSPITALIZED IN THE LAST THREE YEARS ?

WHY ? _____

4. Yes No IS PATIENT BEING TREATED BY A PHYSICIAN NOW ?

WHY ? _____

5. Yes No IS PATIENT BEING HAD PROBLEMS WITH PRIOR DENTAL OR ORTHODONTIC TREATMENT ?

HAS PATIENT EXPERIENCED ?

6. Yes No CHEST PAIN (Angina) ?
7. Yes No SWOLLEN ANKLES ?
8. Yes No SHORTNESS OF BREATH ?
9. Yes No RECENT WEIGHT LOSS, FEVER, CHILLS ?
10. Yes No PERSISTENT COUGH, COUGHING UP BLOOD ?
11. Yes No BLEEDING PROBLEMS, BRUISING EASILY ?
12. Yes No SINUS PROBLEMS ?
13. Yes No DIFFICULTY SWALLOWING ?
14. Yes No DIARRHEA, CONSTIPATION, BLOODY STOOLS ?
15. Yes No FREQUENT VOMITING, NAUSEA ?
16. Yes No DIFFICULTY URINATING, BLOOD IN URINE ?
17. Yes No DIZZINESS ?
18. Yes No RINGING IN EARS ?
19. Yes No HEADACHES ?
20. Yes No FAINTING SPELLS ?
21. Yes No BLURRED VISION ?
22. Yes No SEIZURES ? (Epilepsy)
23. Yes No EXCESSIVE THIRST ?
24. Yes No FREQUENT URINATION ?
25. Yes No DRY MOUTH ?
26. Yes No JAUNDICE ?
27. Yes No JOINT PAIN, STIFFNESS ?

HAS PATIENT EVER HAD ?

28. Yes No HEART DISEASE ?
29. Yes No HEART ATTACK, HEART DEFECTS ?
30. Yes No HEART MURMURS ?
31. Yes No RHEUMATIC FEVER ?
32. Yes No STROKE, HARDENING OF ARTERIES ?
33. Yes No HIGH BLOOD PRESSURE ?
34. Yes No TB, EMPHYSEMA, OTHER LUNG DISEASES ?
35. Yes No HEPATITIS, OTHER LIVER DISEASES ?
36. Yes No STOMACH PROBLEMS, ULCERS ?
37. Yes No ALLERGIES: TO DRUGS, FOODS, OR LATEX ?
38. Yes No OSTEOPOROSIS ?
39. Yes No NERVOUSNESS OR HYPERACTIVITY ?
40. Yes No AIDS or ARC ?
41. Yes No TUMORS, CANCER ?
42. Yes No ARTHRITIS, RHEUMATISM ?
43. Yes No EYE DISEASES ?
44. Yes No SKIN DISEASES ?
45. Yes No ANEMIA ?
46. Yes No VD, SYPHILIS or GONORRHEA ?
47. Yes No HERPES ?
48. Yes No KIDNEY, BLADDER DISEASE ?
49. Yes No THYROID, ADRENAL DISEASE ?
50. Yes No DIABETES ?

DOES PATIENT HAVE OR EVER EXPERIENCED ?

51. Yes No PSYCHIATRIC CARE ?
52. Yes No RADIATION TREATMENTS ?
53. Yes No CHEMOTHERAPY ?
54. Yes No PROSTHETIC HEART VALVE ?
55. Yes No ARTIFICIAL JOINT ?
56. Yes No EMOTIONAL PROBLEMS, TENSION ?
57. Yes No BLOOD TRANSFUSION ?
58. Yes No SURGERIES ?
59. Yes No PACEMAKER ?
60. Yes No CONTACT LENSES ?

IS PATIENT TAKING ?

61. Yes No RECREATIONAL DRUGS ?
62. Yes No DRUGS, MEDICINES (incl. Aspirin) ?
63. Yes No TOBACCO IN ANY FORM ?
64. Yes No ALCOHOL ?

Please list: _____, _____, _____, _____

FEMALE PATIENT'S ONLY:

65. Yes No ARE YOU OR COULD YOU BE PREGNANT ?
66. Yes No PRESENTLY IN THE MENOPAUSE ?
67. Yes No TAKING BIRTH CONTROL PILLS ?
68. Yes No PAST MENOPAUSE ?

ALL PATIENTS

70. Yes No DO YOU HAVE OR HAVE HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM ?

IF SO, PLEASE EXPLAIN: _____

I have answered every question accurately. I will inform this office of any change in my health.

Patient/Parent's Signature _____ Date _____

Reviewed by _____ Date _____