

CONFIDENTIAL HEALTH HISTORY

IN ORDER TO PROTECT YOUR HEALTH, IT IS ESSENTIAL THAT YOU ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY. THANK YOU.

MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

Name and Address of Family Physician _____

Date of last complete physical _____ Physician's Phone Number _____

Are you Presently Under the Care of a Physician Yes No If yes, Why _____

Have You Ever Been Hospitalized Yes No

If Yes, Why _____ When _____

What Medications are You Allergic to _____

What Medications are You Taking _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	_____	_____	Abnormal Bleeding	_____	_____	Ulcers	_____	_____
Heart Murmur	_____	_____	Tobacco Use	_____	_____	Anorexia/Bulimea	_____	_____
Heart Attack	_____	_____	Asthma	_____	_____	Nervous Condition	_____	_____
Angina	_____	_____	Shortness of Breath	_____	_____	Recreational Drug Use	_____	_____
Stroke	_____	_____	Artificial Joint	_____	_____	Hepatitis	_____	_____
High Blood Pressure	_____	_____	Artificial Valve	_____	_____	Liver Disorder	_____	_____
Low Blood Pressure	_____	_____	Bronchitis	_____	_____	Jaundice	_____	_____
Cardiac Pacemaker	_____	_____	Emphysema	_____	_____	Kidney Trouble	_____	_____
Fainting	_____	_____	Anemia	_____	_____	Tuberculosis	_____	_____
Dizzy Spells	_____	_____	Blood Disorder	_____	_____	Diabetes	_____	_____
Seizures	_____	_____	Bone Disorder	_____	_____	Thyroid Disorder	_____	_____
Epilepsy	_____	_____	Cancer Treatment	_____	_____	Venereal Disease	_____	_____
Reaction to a Drug	_____	_____	Alcohol Consumption	_____	_____	Psychiatric Care	_____	_____
Blood Transfusion	_____	_____	Intestinal Problems	_____	_____	AIDS/ARC/HIV Positive	_____	_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? PLEASE INDICATE: _____

Women: Are You Pregnant _____ What Month _____ Are You Nursing _____ Are You Taking Contraceptive Drugs _____

DENTAL HISTORY

What did you like or dislike about your previous Dentist/Dental office? _____

Approximate Date of Last Visit to Dentist _____ Dentist Name _____

Address _____

May We Request X-Rays _____

YES NO

Do You Feel Nervous About Having Dental Treatment? _____

Have You Had Any Trouble Associated with Previous Dental Treatment? _____

Have You Ever Had Gum Treatments? _____

Are You Unhappy With Your Smile? _____

Do You Usually Use "Novacaine" for Dental Treatment? _____

AFTER COMPLETING ALL QUESTIONS, PLEASE DATE AND SIGN. YOUR SIGNATURE ATTESTS TO THE FACT THAT THE INFORMATION YOU PROVIDE ON THIS FORM IS COMPLETE AND TRUE TO THE BEST OF YOUR KNOWLEDGE. IN ADDITION, IT CONFIRMS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGE IN THE FOREGOING HISTORY.

Date: _____ Signature: _____

MEDICAL HISTORY UPDATED BY	DATE	MEDICAL HISTORY UPDATED BY	DATE

Notes:

HEALTH HISTORY