I. CIRCLE APPROPRIATE ANSWERS *(If you do not understand the question, leave the answer blank.):*

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam: _____ Date of last Dental exam: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. CIRCLE APPROPRIATE ANSWERS

7.	Yes	No	Chest pain (angina)?	*18.*	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	*19.*	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	*20.*	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	*21.*	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	*22.*	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	*23.*	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	*24.*	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	*25.*	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	*26.*	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	*27.*	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	*28.*	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	*40.*	Yes	No	HIV/AIDS
30.	Yes	No	Heart attack, heart defects?	*41.*	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	*42.*	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	*43.*	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	*44.*	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	*45.*	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	*46.*	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	*47.*	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	*48.*	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	*49.*	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	*50.*	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	*56.*	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	*57.*	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	*58.*	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	*59.*	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	*60.*	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	*63.*	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines	*64.*	Yes	No	Alcohol?
62b.	Yes	No	Have you ever taken drugs for osteoporosis (Biphosphonates such as Fosamax, Actonel, Zometa).				

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing? *66.* Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature	Date	Signature, reviewing doctor	Date

Notes: _____

Form # 41009 rev: 0308

DENTAL PATIENT
HEALTH HISTORY

Patient Name: _____

DOB: _____

Dental Record #: _____