

First Name _____
Last Name _____
Responsible Party _____
Address _____
Apt _____ City _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
E-Mail address _____

Social Security # _____
Date of Birth _____
Employer _____
Dental Insurance _____
Spouse Name _____
Referred By _____
Which # is the best to reach you? _____

HEALTH HISTORY:

I. CIRCLE APPROPRIATE ANSWER

- 1. Yes No Have you been hospitalized or had a serious illness in last three years?
If YES, WHY?
2. Yes No Are you being treated by a physician now? For what?
Date of last dental exam?

II. HAVE YOU EXPERIENCED

- 7. Yes No Chest pain (angina)?
8. Yes No Shortness of breath?
9. Yes No Bleeding problems, bruising easily?
10. Yes No Difficulty swallowing?
11. Yes No Dry mouth?

III. DO YOU HAVE OR HAVE YOU HAD:

- 12. Yes No Heart Disease?
13. Yes No Heart attack, Heart defects?
14. Yes No Heart murmurs?
15. Yes No Rheumatic fever?
16. Yes No Stroke, hardening of arteries?
17. Yes No High blood pressure?
18. Yes No Asthma, TB, emphysema, other lung diseases?
19. Yes No Hepatitis, other liver disease?
20. Yes No Stomach problems, ulcers?
21. Yes No HIV / AIDS?
22. Yes No Diabetes?
23. Yes No Tumors, cancer?
24. Yes No Arthritis, Rheumatism?
25. Yes No Eye diseases?
26. Yes No Kidney, bladder disease?
27. Yes No Thyroid, adrenal disease?
28. Yes No VD (syphilis or gonorrhoea)?
29. Yes No Herpes?
30. Yes No Allergies to: drugs, foods, medications, Latex?

IV. DO YOU HAVE OR HAVE YOU HAD:

- 31. Yes No Prosthetic heart valve?
32. Yes No Artificial Joint?
33. Yes No Pace maker?

V. ARE YOU TAKING:

- 34. Yes No Recreational Drugs?
35. Yes No Drugs, medications, over-the counter Medicines (including Aspirin), natural remedies?
36. Yes No Tobacco in any form?
37. Yes No Alcohol?

Please list: _____

VI. WOMEN ONLY:

- 38. Yes No Are you or could you be pregnant or nursing?
39. Yes No Taking birth control pills?

VII. ALL PATIENTS:

- 40. Yes No Do you have or have you had any other disease 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 changes in my health and/or medication.

Patient's Signature: _____ Date: _____