PATIENT HEALTH HISTORY

Patient Name	Date of Birth	Today's Date
______________________________	_____/_____/_____	_____/_____/_____

Reason for Appointment: ____

Date of last dental exam: _____/_____/_____

Date of last medical exam: _____/_____/_____

Have you been in the hospital in the last 5 years? ☐ Yes ☐ No

If yes, for what: ____

Do you have or have you ever had:

Condition	Yes	No
Hip or Joint Replacement	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Heart Murmur/Mitral Valve Prolapsed	☐ Yes	☐ No
Abnormal Heart Condition	☐ Yes	☐ No
Abnormal Bleeding from a Cut	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Recurring Illnesses	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Unintentional Weight Loss	☐ Yes	☐ No
GERD/Acid Reflux	☐ Yes	☐ No
Thyroid Issues	☐ Yes	☐ No

Allergies:

Allergy	Yes	No
To Penicillin	☐ Yes	☐ No
To Local Anesthetic	☐ Yes	☐ No
To medications	☐ Yes	☐ No
To Latex	☐ Yes	☐ No

Any Other Allergies: ____

Please answer yes or no to the following questions:

Question	Yes	No
Are you having or have you ever had radiation treatment?	☐ Yes	☐ No
Do you smoke or use smokeless tobacco?	☐ Yes	☐ No
Do you use drugs and/or alcohol?	☐ Yes	☐ No
(Women) Are you pregnant?	☐ Yes	☐ No
Are you taking any medications?	☐ Yes	☐ No

If so what? ____

____

Other Physical Conditions: ____

Blood pressure if known ___________/__________

Name of Physician ____

Physician's Phone Number ____________________________

Are you under the care of a physician now? ☐ Yes ☐ No

If so, nature of the care? ____

Signature of person filling out this health history form: __________________________

FOR OFFICE USE ONLY:

Signature of person reviewing this health history form:

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