**PATIENT HEALTH HISTORY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name/Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of Birth \_\_\_\_/\_\_\_/\_\_\_\_\_ Cell/Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Reason for Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Date of last dental exam (If new patient): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | | | | | | | |
| Date of last medical exam: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | | | | | | FOR OFFICE USE ONLY: | |
| Have you been in the hospital in the last 5 years? ../../../yTogj4zEc.png Yes ../../../yTogj4zEc.png No | | | | | | |
| If yes, for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Do you have or have you ever had: | | | | | | |
|  | Hip or Joint Replacement | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | High Blood Pressure | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Anemia | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Hepatitis | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Jaundice | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Cancer | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Diabetes | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Epilepsy/Seizures | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Rheumatic Fever | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Heart Disease | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Heart Murmur/Mitral Valve Prolapsed | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Abnormal Heart Condition | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Abnormal Bleeding from a Cut | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Venereal Disease | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | AIDS/HIV | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Recurring Illnesses | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Ulcers | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Unintentional Weight Loss | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | GERD/Acid Reflux | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Thyroid Issues | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
| Allergies: | | | | | | |
|  | To Penicillin | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | To Local Anesthetic | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | To medications | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | To Latex | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No | | |
|  | Any Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Please answer yes or no to the following questions: | | | | | | |
|  | Are you having or have you ever had radiation treatment? | | | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No |
|  | Do you smoke or use smokeless tobacco? | | | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No |
|  | Do you use drugs and/or alcohol? | | | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No |
|  | (Women) Are you pregnant? | | | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png No |
|  | Are you taking any medications? | | | | ../../../yTogj4zEc.png Yes | ../../../yTogj4zEc.png 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? ../../../yTogj4zEc.png Yes ../../../yTogj4zEc.png No | | | | | | |
| Signature of person reviewing this health history form:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| If so, nature of the care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Signature of person filling out this health history form:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_ | | | | | | |