**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:\_\_\_\_\_\_\_\_\_ |