# 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: _____/_____/_____

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:

| | | |
|---|---|---|
| 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:

| | | |
|---|---|---|
| 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:

| | | |
|---|---|---|
| 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:

_____Date:_____

FOR OFFICE USE ONLY:

Signature of person reviewing this health history form:

_____