PATIENT HEALTH HISTORY

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: High or Joint Replacement Ves No Anemia Ves No Anemia Ves No Anemia Ves No Jaundice Ves No Cancer Cancer Ves No Diabetes Ves No Epilepsy/Selzures Heart Murmur/Mitral Valve Prolapsed Heart Murmur/Mitral Valve Prolapsed Heart Murmur/Mitral Valve Prolapsed Abnormal Bleeding from a Cut Ves No Abnormal Bleeding from a Cut Ves No Venereal Disease Heart Murmur/Mitral Valve Prolapsed Ves No Abnormal Bleeding from a Cut Ves No Auto-Malormal Bleeding from a Cut Ves No Alborhal Bleeding from a Cut Ves No GERD/Acid Reflux Venereal Disease Ves No AIDS/HIV Recurring illnesses Ves No GERD/Acid Reflux Ves No GERD/Acid Reflux Ves No To Local Anesthetic To Denicillin Ves No To Lacal Anesthetic Ves No Any Other Allergies: Are you having or have you ever had radiation treatment? (Women) Are you pregnant? Are you taking any medications? If so what?
Hip or Joint Replacement
Hijp or Joint Replacement
High Blood Pressure
Anemia
Hepatitis
Jaundice
Cancer
Diabetes
Rheumatic Fever
Heart Disease 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 Ulcers Yes No Unintentional Weight Loss Yes No GERD/Acid Reflux Yes No Thyroid Issues Yes No To Penicillin Yes No To Local Anesthetic Yes No To medications Yes No To Latex 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 use drugs and/or alcohol? Yes No If so what?
Heart Murmur/Mitral Valve Prolapsed
Abnormal Heart Condition
Abnormal Bleeding from a Cut
Venereal Disease
AIDS/HIV
Recurring Illnesses
Ulcers
Unintentional Weight Loss
Thyroid Issues
Allergies: To Penicillin
To Penicillin
To Local Anesthetic
To medications
To Latex Any Other Allergies: Please answer yes or no to the following questions: Are you having or have you ever had radiation treatment? Do you smoke or use smokeless tobacco? Do you use drugs and/or alcohol? (Women) Are you pregnant? Are you taking any medications? If so what?
Any Other Allergies:
Please answer yes or no to the following questions: Are you having or have you ever had radiation treatment? Do you smoke or use smokeless tobacco? Do you use drugs and/or alcohol? (Women) Are you pregnant? Are you taking any medications? If so what?
Do you smoke or use smokeless tobacco? Do you use drugs and/or alcohol? (Women) Are you pregnant? Are you taking any medications? If so what?
Do you use drugs and/or alcohol? (Women) Are you pregnant? Are you taking any medications? If so what?
(Women) Are you pregnant? Are you taking any medications? If so what? ———————————————————————————————————
Are you taking any medications? If so what? ———————————————————————————————————
If so what?
Others Blooding Constitutions
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 Signature of person reviewing this health history form:
If so, nature of the care?Signature of person filling out this health history form:
Date