HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name: ____ **Date of Birth:** ______________ **Age:** _____________

Please answer each question by checking Yes or No. If not sure, please leave blank:

Are you in currently in good health? .... Yes _____ No ______

Are you currently under the care of a physician? .... Yes _____ No ______

If yes, what is the condition being treated? ____

Have you ever been hospitalized or had a serious illness? .... Yes _____ No ______

If yes, please explain: ____

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes__No___

Do you use tobacco in any form? If yes, which type and how much? __________________________ Yes _____ No ______

Do you us alcoholic beverages (more than 2 drinks per day)? .... Yes ____ No ______

Do you have or have you ever had any of the following?

GENERAL

Tire easily, weakness .... Yes ____ No ____

Marked weight change .... Yes ____ No ____

Night sweats .... Yes ____ No ____

Persistent fever .... Yes ____ No ____

SKIN

Eurptions (rash) hives .... Yes ____ No ____

Change in skin color .... Yes ____ No ____

EYES

Visual changes .... Yes ____ No ____

Glaucoma .... Yes ____ No ____

EARS

Loss of hearing .... Yes ____ No ____

Ringing in the ears .... Yes ____ No ____

NOSE

Frequent nosebleeds .... Yes ____ No ____

Sinus problems .... Yes ____ No ____

THROAT

Soreness/hoarseness .... Yes ____ No ____

NERVOUS SYSTEM

Stroke .... Yes ____ No ____

Headaches .... Yes ____ No ____

Convulsions/epilepsy .... Yes ____ No ____

Numbness/tingling .... Yes ____ No ____

Dizziness/fainting .... Yes ____ No ____

Psychiatric treatment .... Yes ____ No ____

RESPIRATORY

Tuberculosis .... Yes ____ No ____

Emphysema .... Yes ____ No ____

Asthma/hay fever .... Yes ____ No ____

Persistent cough .... Yes ____ No ____

Sputum production (phlegm).. Yes ____ No ____

Cough up bloody sputum .... Yes ____ No ____

Difficulty breathing while lying downYe ____ No ____

ENDOCRINE

Diabetes .... Yes ____ No ____

Family history of diabetes...... Yes ____ No ____

Thyroid condition/goiter .... Yes ____ No ____

Other .... Yes ____ No ____

HEART/BLOOD VESSELS

Rheumatic fever .... Yes ____ No _____

Heart murmur............................ Yes ____ No _____

Chest pain/discomfort .... Yes ____ No _____

Heart attack/trouble .... Yes ____ No _____

Shortness of breath .... Yes ____ No _____

Swelling of ankles .... Yes ____ No _____

High blood pressure .... Yes ____ No _____

Congenital heart disease .... Yes ____ No _____

Mitral Valve Prolapse .... Yes ____ No _____

Artificial heart valve .... Yes ____ No _____

Pacemaker .... Yes ____ No _____

Heart surgery .... Yes ____ No _____

Other .... Yes ____ No _____

BONE/MUSCLES

Arthritis/rheumatism .... Yes ____ No _____

Artificial joints/limbs .... Yes ____ No _____

DIGESTIVE SYSTEM

Hepatitis .... Yes ____ No ____

Jaundice .... Yes ____ No ____

Ulcers .... Yes ____ No ____

Change in appetite .... Yes ____ No ____

Black, bloody or pale stools .... Yes ____ No ____

URINARY

Kidney disease .... Yes ____ No ____

Increase in frequency of urination (night)Yes___No ____

Burning on urination .... Yes ____ No ____

Urethral discharge .... Yes ____ No ____

Bloody urine .... Yes ____ No ____

Venereal disease .... Yes ____ No ____

BLOOD

Bruise easily .... Yes ____ No ____

Anemia .... Yes ____ No ____

Blood transfusion .... Yes ____ No ____

OTHER

Latex Sensitivity .... Yes ____ No ____

Radiation or Chemotherapy .... Yes ____ No ____

Tumors or growths .... Yes ____ No ____

Cancer .... Yes ____ No ____

HIV+ or AIDS .... Yes ____ No ____