

## CONFIDENTIAL HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?  
If NO, explain: \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain: \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain: \_\_\_\_\_
4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam: \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain: \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_
6. Yes / No Are you in pain now?  
If YES, explain: \_\_\_\_\_

### II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |
- Other: \_\_\_\_\_

### III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |  |  |                                       |
|--|--|---------------------------------------|
| Yes / No Heart disease                   | Yes / No AIDS/HIV                        | Yes / No Psychiatric care             |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis                 |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease              |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                       |
| Type/ Date of surgery: _____             |  |                                       |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                    |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexually transmitted disease |
| Yes / No Pacemaker                       |  |                                       |
| Date implanted: _____                    |  |                                       |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                       |
| Yes / No Rheumatic fever                 | Yes / No Radiation                       | Yes / No Canker or cold sores         |
| Yes / No Skin disease                    | Yes / No Arthritis, rheumatism           | Yes / No Anemia                       |
| Yes / No Hardening of arteries           | Yes / No Emphysema or other lung disease | Yes / No Liver disease                |
| Yes / No High blood pressure             | Yes / No Kidney or bladder disease       | Yes / No Eye disease                  |
| Yes / No Seizures                        | Yes / No Stroke                          | Yes / No Transplants                  |
| Yes / No Cosmetic surgery                | Yes / No Eating disorders                | Yes / No Tuberculosis                 |

Other: \_\_\_\_\_

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or sedatives	Yes / No	Codeine or other opioids
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: \_\_\_\_\_

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Antidepressants	Yes / No	Herbal supplements		

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: \_\_\_\_\_

Please list all prescription medications: \_\_\_\_\_

**VI. WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months? \_\_\_\_\_

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

**VII. ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?  
If YES, please explain: \_\_\_\_\_

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: \_\_\_\_\_

Yes / No Have you tested positive for COVID-19?  
If YES, date of positive test result: \_\_\_\_\_

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?  
If YES, what are these symptoms or effects? \_\_\_\_\_

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?  
If YES, please list \_\_\_\_\_

*If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.*

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Whom would you like us to contact in case of an emergency?):**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

**MEDICAL UPDATES**

I have reviewed my Health History and confirm that it accurately states past and present conditions.

<b>DATE</b>	<b>PATIENT SIGNATURE</b>	<b>CHANGES TO HEALTH HISTORY</b>	<b>DENTIST INITIALS</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____