PATIENT HEALTH HISTORY

CONFIDENTIAL

PATIENT'S NAME________________________________

Physician's Name __________________________________ Phone _________________ Date of last visit ______________

Check the box "yes" or "no" to indicate if you have had any of the following:

Condition		
AIDS/HIV	Yes	No
Alzheimer's Disease	Yes	No
Anemia	Yes	No
Arthritis, Rheumatism	Yes	No
Artificial Heart Valves	Yes	No
Artificial joints	Yes	No
Year_______ what __________________		
Asthma	Yes	No
Back Problems	Yes	No
Bleeding abnormally, w/ extractions or surgery	Yes	No
Blood Disease	Yes	No
Blood Transfusions	Yes	No
Brain Damage	Yes	No
Cancer of ____________	Yes	No
Chemical Dependency	Yes	No
Chemotherapy	Yes	No
Circulatory Problems	Yes	No
Congenital Heart Lesions	Yes	No
Cortisone Treatments	Yes	No
Cough, persistent or bloody	Yes	No
Diabetes	Yes	No
Emphysema	Yes	No
Epilepsy	Yes	No
Fainting or dizziness	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Heart Murmur	Yes	No
Heart Problems	Yes	No
Heart Surgery	Yes	No
Hepatitis - Type _____	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Jaundice	Yes	No
Jaw Pain	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Mental Retardation	Yes	No
Mitral-Valve Prolapse	Yes	No
Nervous Problems	Yes	No
Pacemaker	Yes	No
Parkinson's Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatment	Yes	No
Respiratory Disease	Yes	No
Rheumatic Fever	Yes	No
Scarlet Fever	Yes	No
Shortness of Breath	Yes	No
Sickle Cell Disease/Trait	Yes	No
Sinus Trouble	Yes	No
Skin Rash	Yes	No
Special Diet	Yes	No
Stroke - year__________	Yes	No
Swollen Feet/Ankles	Yes	No
Swollen Neck glands	Yes	No
Thyroid Problems	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumor or growth on head or neck	Yes	No
Ulcer	Yes	No
Venereal Disease	Yes	No
Weight Loss, unexplained	Yes	No
WOMEN ONLY:		
Pregnant/may be pregnant	Yes	No
Due date:__________________		
Nursing	Yes	No
Taking birth control pills	Yes	No

OTHER:

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____

MEDICATIONS: None See List

List any medications you are currently taking and the correlating diagnosis:

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ALLERGIES: none

- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Iodine
- Local Anesthetic
- Latex
- Sulfa
- Penicillin
- Other ___________________________

Are antibiotics required before dental treatment?
Yes **with** _______________ No

Have you ever taken **BISPHOSPHONATE** (Osteoporosis) medications? No

Yes - Give History:____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate answers can be dangerous to my health. I authorize the dental facility to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to any health practitioners.

Signature of Patient (over 18) OR **Parent/Guardian** (If Minor) ____

Relationship to Patient ______________________________ Date ____________________________

Heath History Review Log

Date / patient initial /staff initial			