HEALTH HISTORY

Patient's Name: _____ Date: _____

Please ✓ Yes or No to each Question. If unsure of a question, please consult with the dentist.

	Yes	No
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____ Has there been any change in your general health in the past year?	☐	☐
2. Have you been hospitalized in the past two years?	☐	☐
3. When was your last visit to a Physician? Last complete physical examination?	☐	☐
4. Have you recently, or are you presently, taking any **PRESCRIPTION or NON-PRESCRIPTION** drugs? If yes, please list: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	☐	☐
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills), CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, any other medicine: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication?	☐	☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions?	☐	☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so please explain: _____	☐	☐
9. Has any family member had diabetes?	☐	☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐	☐
11. Do your ankles, feet or hands swell?	☐	☐
12. Has your weight, appetite or energy level changed dramatically recently?	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
14. Do you follow a special diet?	☐	☐
15. Have you tested HIV positive?	☐	☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	☐	☐
17. Have you ever had any injury or surgery to your face or jaws?	☐	☐
18. Do you wear eyeglasses or contact lenses?	☐	☐
19. Do you have any hearing difficulties?	☐	☐
20. Do you smoke or use any other forms of tobacco? Are you wearing the transdermal nicotine patch?	☐	☐
21. Are you alcohol and/or drug dependent? and, Have you received treatment?	☐	☐

22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	Yes	No		Yes	No		Yes	No
A.I.D.S.	☐	☐	Congenital heart lesions	☐	☐	Heart murmur	☐	☐
Anemia	☐	☐	Cortisone/steroid	☐	☐	Heart pacemaker	☐	☐
Angina pectoris	☐	☐	Diabetes	☐	☐	Heart rhythm disorder	☐	☐
Arthritis/rheumatism	☐	☐	Emphysema	☐	☐	Heart surgery	☐	☐
Artificial heart valve	☐	☐	Epilepsy or seizures	☐	☐	Hepatitis A	☐	☐

MEDICAL HISTORY **MEDICAL HISTORY UPDATES**

	Yes	No
Artificial joints (hip, knee)		
Blood disorders		
Bronchitis		
Cancer		
Circulation problems		
Hyper(Hypo) Glycemia		
Hypertension		
Jaundice		
Kidney disease		
Liver disease		
Lung disease		
Malignant Hyperthermia		
Mental/nervous disorder		
Mitral valve prolapse		
Organ transplant		

	Yes	No
Fainting or dizzy spells		
Glandular disorders		
Glaucoma		
Head/neck injuries		
Heart disease or attack		
Medical implant		
Psychiatric treatment		
Radiation treatment		
Chemotherapy		
Rheumatic/Scarlet fever		
Sickle cell disease		
Sinus trouble		
Stomach problems		
Intestinal problems		
Stroke		

	Yes	No
Hepatitis B		
Hepatitis C		
Herpes		
High/Low blood pressure		
Hodgkins disease		
Thyroid disease		
Tuberculosis		
Ulcers		
Venereal disease		
Other _____		
Other _____		
Other _____		
_____		
_____		
_____		

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date)

Measles _____			Strep throat _____	
Mumps _____			Tonsillitis _____	
Chicken Pox _____			Other _____	

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____
25. Is there anything else about your health we should be made aware of? _____
26. Do you wish to speak to the Doctor privately about any problem or medical condition? _____

27. **WOMEN ONLY:** Are you pregnant or suspect you may be?

If yes, what is the expected delivery date? _____ Are you taking any birth control pills?

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

PATIENT ☐ PARENT ☐ GUARDIAN ☐ (PRINT NAME OF GUARDIAN)

Doctor's comments: _____

Reviewed by Treating Dentist: _____ **Date:** _____

FORM: DMDSELREG/HH/V1 CUSTOM

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