Confidential Health History

Patient Name: _____ DOB: _____

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 Have you ever had any surgeries?
   If YES, explain: _____
3. Yes / No Have you ever been hospitalized or had a serious illness?
   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: _____

II. **HAVE YOU EVER HAD / DO YOU HAVE ANY OF THE FOLLOWING?** (Circle Yes or No)

Yes / No Heart disease	Yes / No Head injuries	Yes / No Thyroid
Yes / No Family history of heart disease	Yes / No Cardiac Shunts	Yes / No Asthma
Yes / No Autoimmune disease	Yes / No Diabetes	Yes / No Hepatitis
Yes / No Artificial joint	Yes / No Family history of diabetes	Yes / No STD's
Yes / No Stomach problems/ulcers	Yes / No Tumors or cancer	Yes / No Herpes
Yes / No Congenital heart defects	Yes / No Chemotherapy	Yes / No Canker or cold sores
Yes / No Heart murmur	Yes / No Radiation	Yes / No Anemia
Yes / No Rheumatic fever	Yes / No Arthritis, rheumatism	Yes / No Liver disease
Yes / No Skin disease	Yes / No Respiratory/lung disease	Yes / No Eye disease
Yes / No Bleeding disorder	Yes / No Kidney/bladder disease	Yes / No Transplants
Yes / No High blood pressure	Yes / No Sleep apnea	Yes / No Tuberculosis
Yes / No Seizures/epilepsy	Yes / No Eating disorders	Yes / No Allergies/Hives
Yes / No Cardiac pacemaker	Yes / No Psychiatric care	Yes / No Autistic spectrum disorder
Yes / No AIDS/HIV	Yes / No Osteoporosis	Yes / No Stroke

Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, explain: _____
Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?
If YES, explain: _____

III. **ARE YOU ALLERGIC TO / HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?** (Circle Yes or No)

Yes / No Aspirin	Yes / No Sedatives	Yes / No Codeine/narcotics
Yes / No Penicillin/antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

IV. **ARE YOU TAKING / HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS** (Circle Yes or No)

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

Please, list all prescription medications: _____

V. **WOMEN ONLY** (Circle Yes or No)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VI. **DENTAL HISTORY** (Circle Yes or No)

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever had local anesthetic (Novocain, etc.)?
Yes / No Have you ever had a reaction from a local anesthetic? If YES, explain: _____
Yes / No Have you ever had excessive bleeding after your dental work?
Yes / No Have you ever had any trouble associated with previous dental work?

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: _____

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

DATE	SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____