

HEALTH HISTORY

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: _____ Physician: _____ Phone: _____
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 incl. herbal remedies
 1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
5. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g. Penicillin, or other antibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or 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. Is there a family history of Diabetes, Cancer or Heart Disease? _____
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 follow a special diet, or are you on a diet pill therapy? _____
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____
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.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Mental/nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/medical implant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints(hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C _____	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever → Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkins disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroid	<input type="checkbox"/>	<input type="checkbox"/>	Hyper (Hypo) Glycemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

23. Has the CHILD PATIENT <u>recently</u> had any of the following: (indicate approximate date.)	Measles _____	<input type="checkbox"/>	<input type="checkbox"/>
	Mumps _____	<input type="checkbox"/>	<input type="checkbox"/>
	Chicken Pox _____	<input type="checkbox"/>	<input type="checkbox"/>
		Strep throat _____	<input type="checkbox"/>
		Tonsillitis _____	<input type="checkbox"/>

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 privately to the Doctor about any problem or medical condition? _____

27. WOMEN ONLY: Are you pregnant or suspect you may be? _____ Expected delivery date? _____
 Are you breast feeding? _____ Are you taking any birth control pills? _____

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

Reviewed by Treating Dentist: _____ Date: _____