

# PATIENT HEALTH HISTORY

1. Name and address of physician \_\_\_\_\_
2. Date of last complete physical \_\_\_\_\_
3. Are you now taking any medications, drugs, or pills? .....Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_
4. Are you being treated by a physician for a specific condition? .....Yes \_\_\_ No \_\_\_  
If so, please list the condition: \_\_\_\_\_
5. Do you bleed excessively when cut?.....Yes \_\_\_ No \_\_\_
6. Have you ever experienced a bad reaction to a dental anesthetic or any materials used in a dental office?.....Yes \_\_\_ No \_\_\_
7. Have you been a patient in the hospital during the past five years?.....Yes \_\_\_ No \_\_\_
8. Have you ever had a serious operation?.....Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_
9. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips?.....Yes \_\_\_ No \_\_\_
10. Are you allergic to any medications, drugs, or pills?.....Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_
11. Do you have any other allergies?.....Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_
12. Do you smoke, use chewing tobacco or snuff?.....Yes \_\_\_ No \_\_\_
13. Do you have or have you ever had the following:
 

Heart Disease	Yes ___ No ___	Diabetes	Yes ___ No ___
Heart Attack	Yes ___ No ___	Thyroid Disease	Yes ___ No ___
Angina Pectoris	Yes ___ No ___	X-Ray or Cobalt Treatment	Yes ___ No ___
Abnormal Blood Pressure	Yes ___ No ___	Chemotherapy (Cancer, Leukemia)	Yes ___ No ___
Heart Murmur	Yes ___ No ___	Arthritis	Yes ___ No ___
Mitral Valve Prolapse	Yes ___ No ___	Glaucoma	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___	Pain in Jaw Joints	Yes ___ No ___
Congenital Heart Lesions	Yes ___ No ___	A.I.D.S.	Yes ___ No ___
Artificial Heart Valve	Yes ___ No ___	Hepatitis A (Infectious)	Yes ___ No ___
Heart Pacemaker	Yes ___ No ___	Hepatitis B (Serum)	Yes ___ No ___
Heart Surgery	Yes ___ No ___	Liver Disease	Yes ___ No ___
Artificial Joints (Hip, Knee)	Yes ___ No ___	Yellow Jaundice	Yes ___ No ___
Anemia	Yes ___ No ___	Drug Addiction	Yes ___ No ___
Stroke	Yes ___ No ___	Hemophilia	Yes ___ No ___
Kidney Trouble	Yes ___ No ___	Blood Transfusion	Yes ___ No ___
Ulcers	Yes ___ No ___	Venereal Disease	Yes ___ No ___
Emphysema	Yes ___ No ___	Cold Sores	Yes ___ No ___
Tuberculosis (TB)	Yes ___ No ___	Epilepsy or Seizures	Yes ___ No ___
Asthma	Yes ___ No ___	Psychiatric Treatment	Yes ___ No ___
14. When you walk up the stairs, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are too tired?.....Yes \_\_\_ No \_\_\_
15. Are you on special diet?.....Yes \_\_\_ No \_\_\_
16. Have you lost or gained more than 10 pounds in the past year?.....Yes \_\_\_ No \_\_\_
17. Has your doctor ever said you have a tumor or cancer?.....Yes \_\_\_ No \_\_\_
18. Have you ever been exposed, or had a probable exposure, to A.I.D.S.?.....Yes \_\_\_ No \_\_\_
19. Do you have any disease, condition, or problem not listed?.....Yes \_\_\_ No \_\_\_
20. FOR WOMEN ONLY:  
Are you pregnant? .....Yes \_\_\_ No \_\_\_  
If yes, what month? \_\_\_\_\_  
Are you taking birth control pills?.....Yes \_\_\_ No \_\_\_
21. Have you taken Phen-fen or Redux?.....Yes \_\_\_ No \_\_\_

The above information is true. If I ever have any change in my health or my medication I will inform the dentist at the next appointment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Guardian \_\_\_\_\_ Relations to Patient \_\_\_\_\_