

# HEALTH HISTORY

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Please answer all questions. If the question is not understood, you are not certain of the answer, or have any questions, indicate so in the space, and discuss the matter with the doctor.

- |  |     |    |
|--|-----|----|
| 1. Are you having pain or discomfort at this time? .....                             | Yes | No |
| 2. Do you feel very nervous about having dental treatment? .....                     | Yes | No |
| 3. Have you ever had a bad experience in the dental office? .....                    | Yes | No |
| 4. Have you been a patient in the hospital during the past two years? .....          | Yes | No |
| 5. Have you been under the care of a medical doctor during the past two years? ..... | Yes | No |

Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone# \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 6. List any surgeries you have had. _____                            |     |    |
| 7. Have you taken any medicine or drugs in the last two years? ..... | Yes | No |
| Are you now taking any medication, drugs or pills? .....             | Yes | No |

If yes, please list \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 8. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... | Yes | No |
| 9. Have you ever had any excessive bleeding requiring special treatment? .....  | Yes | No |
| 10. Circle any of the following which you have had or have at present:  |     |    |

- |                              |                                 |  |
|------------------------------|---------------------------------|--|
| Heart Failure                | Emphysema                       | A.I.D.S.                               |
| Heart Disease or Attack      | Cough                           | Hepatitis A (infectious)               |
| Angina Pectoris              | Tuberculosis (TB)               | Hepatitis B (Serum)                    |
| High Blood Pressure          | Asthma                          | Liver Disease                          |
| Heart Murmur                 | Hay Fever                       | Yellow Jaundice                        |
| Rheumatic Fever              | Sinus Trouble                   | Blood Transfusion                      |
| Congenital Heart Lesions     | Allergies or Hives              | Bruise Easily                          |
|                              |                                 | Drug Addiction                         |
| Scarlet Fever                | Diabetes                        | Hemophilia                             |
| Artificial Heart Valve       | Thyroid Disease                 | Venereal Disease (Syphilis, Gonorrhea) |
| Heart Pacemaker              | X-ray or Cobalt Treatment       | Cold Sores                             |
| Heart Surgery                | Chemotherapy (Cancer, Leukemia) | genital Herpes                         |
| Artificial Joint (hip, Knee) | Arthritis                       | Epilepsy or Seizures                   |
| Anemia                       | Rheumatism                      | Fainting or dizzy Spells               |
| Stroke                       | Cortisone Medicine              | Nervousness                            |
| Kidney Trouble               | Glaucoma                        | Psychiatric Treatment                  |
| Ulcers                       | Pain in Jaw Joints              | Sickle Cell Disease                    |

- |  |     |    |
|--|-----|----|
| 11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... | Yes | No |
| 12. Do your ankles swell during the day? .....   | Yes | No |
| 13. Do you use more than 2 pillows to sleep? .....   | Yes | No |
| 14. Have you lost or gained more than 10 pounds in the last year? .....  | Yes | No |
| 15. Do you ever wake up from sleep short of breath? .....  | Yes | No |
| 16. Are you on a special diet? .....   | Yes | No |
| 17. Has your medical doctor ever said you have a cancer or tumor? .....  | Yes | No |
| 18. Do you have any disease, condition or problem not listed? .....  | Yes | No |
| 19. WOMEN: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what month? _____ Are you taking birth control pills? .....        | Yes | No |

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

\_\_\_\_\_  
 Date Signature of Patient Signature of Doctor

**CONSENT:**  
 The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) \_\_\_\_\_. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. A \$25.00 fee will be assessed to account for returned checks. Failed appointments are subject to a \$25.00 charge unless a 24 hour advance cancellation notice is given. I authorize the release of any requested health records.

Patient \_\_\_\_\_ Date \_\_\_\_\_