

## HEALTH HISTORY

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (please circle)      No    Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care?      No    Yes      If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. Phone: \_\_\_\_\_
2. Phone: \_\_\_\_\_
3. Phone: \_\_\_\_\_

|  |    |     |                                    |    |     |
|--|----|-----|------------------------------------|----|-----|
| Heart Murmur                             | No | Yes | Sexually Transmitted Disease       | No | Yes |
| Anemia                                   | No | Yes | Sore/Enlarged Lymph Nodes          | No | Yes |
| Diabetes                                 | No | Yes | Previous Biopsies                  | No | Yes |
| Epilepsy                                 | No | Yes | Slow-Healing Mouth Sores           | No | Yes |
| Hepatitis, Any Form                      | No | Yes | Other Infections                   | No | Yes |
| Rheumatic Fever                          | No | Yes | Recurrent Illnesses                | No | Yes |
| Asthma                                   | No | Yes | Joint Replacement                  | No | Yes |
| HIV Positive or AIDS Related Complex     | No | Yes | Glaucoma                           | No | Yes |
| Emphysema or other Respiratory Illnesses | No | Yes | Abnormal Bleeding from a cut       | No | Yes |
| Abnormal Heart Condition                 | No | Yes | Liver disease (including Jaundice) | No | Yes |
| Kidney Disease                           | No | Yes | Unintentional Weight Loss          | No | Yes |
| Psychosis                                | No | Yes | Unintentional Weight Gain          | No | Yes |

Are you required to Pre-Medicate before dental treatment?      No    Yes

Women: Are you pregnant? No Yes If no, are you planning a pregnancy in the near future? No Yes

Mothers: Are you nursing?      No    Yes

Abnormal Blood Pressure? (please circle)      No    Yes      If yes, what is it usually? S      /D

Are you allergic to any medications/drugs?      No    Yes If yes, please list: \_\_\_\_\_

Are you allergic to or have you ever had any unusual reactions to a local anesthetic?      No    Yes

Are you a smoker?      No    Yes      If so, how much do you smoke per day? \_\_\_\_\_

Please list any medications you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you taking Tagamet (Cimetidine)?      No    Yes      If yes, how often? \_\_\_\_\_

Are you taking any Antacids?      No    Yes      If yes, how often? \_\_\_\_\_

Are you taking any herbal supplements/medicines?      No    Yes      If yes, which ones? \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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