

HEALTH HISTORY

PATIENT NAME:		DATE OF BIRTH:			
NAME OF M.D.:					
ARE YOU BEING TREATED BY A PHYSICIAN NOW?					
FOR WHAT?					
DATE OF LAST MEDICAL EXAM:			DATE OF LAST DENTAL EXAM:		
YES	NO	CHECK (✓) APPROPRIATE ANSWER (Leave blank if you don't understand question)			
		IS YOUR GENERAL HEALTH GOOD?			
		HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?			
		HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS? WHY?			
		HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT?			
		ARE YOU IN PAIN NOW?			
YES	NO	HAVE YOU EXPERIENCED?	YES	NO	HAVE YOU EXPERIENCED?
		CHEST PAIN (ANGINA)?			BLURRED VISION?
		SWOLLEN ANKLES?			SEIZURES?
		SHORTNESS OF BREATH?			EXCESSIVE THIRST?
		SINUS PROBLEMS?			FREQUENT URINATION?
		DIFFICULTY SWALLOWING?			DRY MOUTH?
		FREQUENT VOMITING, NAUSEA?			JAUNDICE?
		DIZZINESS?			JOINT PAIN, STIFFNESS?
		HEADACHES?			RINGING IN EARS?
		FAINING SPELLS?			PERSISTENT COUGH, COUGHING UP BLOOD?
		BLEEDING PROBLEMS, BRUISING EASILY?			DIARRHEA, CONSTIPATION, BLOOD IN STOOLS?
		DIFFICULTY URINATING, BLOOD IN URINE?			
YES	NO	DO YOU HAVE OR HAVE YOU HAD?	YES	NO	DO YOU HAVE OR HAVE YOU HAD?
		HEART DISEASE?			DIABETES?
		HEART ATTACK, HEART DEFECTS?			FAMILY HISTORY OF DIABETES, HEART PROBLEMS, TUMORS?
		HEART MURMURS?			AIDS OR ARC?
		RHEUMATIC FEVER?			TUMORS, CANCER?
		STROKE, HARDENING OF ARTERIES?			ARTHRITIS, RHEUMATISM?
		HIGH BLOOD PRESSURE?			EYE DISEASES?
		STOMACH PROBLEMS?			ULCERS?
		SKIN DISEASES?			ANEMIA?
		THYROID, ADRENAL DISEASE?			KIDNEY, BLADDER DISEASE?

YES	NO	DO YOU HAVE OR HAVE YOU HAD?	YES	NO	DO YOU HAVE OR HAVE YOU HAD?
		ALLERGIES: LATEX MEDICINES FOODS METALS			VD (SYPHILIS OR GONORRHEA?)
		KIDNEY, BLADDER DISEASE?			HERPES?
		RADIATION TREATMENTS?			CHEMOTHERAPY?
		PROSTHETIC HEART VALVE?			ARTIFICIAL JOINT?
		IMPLANTS-BREAST, PENILE, OTHER?			HOSPITALIZATION?
		BLOOD TRANSFUSIONS?			SURGERIES?
		PACEMAKER?			CONTACT LENSES?
		HEPATITIS, OTHER LIVER DISEASE?			PSYCHIATRIC CARE?
YES	NO	ARE YOU TAKING?			
		RECREATIONAL DRUGS?			
		ALCOHOL?			
		TOBACCO IN ANY FORM?			
		DRUGS, MEDICINES, (INCLUDING ASPIRIN)? PLEASE LIST:			
YES	NO	WOMEN ONLY			
		ARE YOU OR COULD YOU BE PREGNANT?			
		ARE YOU TAKING BIRTH CONTROL PILLS?			
YES	NO	ALL PATIENTS			
		DO YOU HAVE OR HAVE YOU HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM? PLEASE LIST:			

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.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

FOR YOUR BENEFIT, A THOROUGH EXAMINATION, FREQUENTLY INCLUDING DENTAL X-RAYS AND DIAGNOSTIC MODELS OF YOUR MOUTH, IS NECESSARY BEFORE WE CAN MAKE AN INTELLIGENT AND EFFICIENT ANALYSIS OF YOUR DENTAL NEEDS. THE SECRETARY CAN ADVISE YOU OF THE FEE FOR THESE SERVICES. AFTER THOROUGH DIAGNOSIS, WE CAN DISCUSS YOUR DENTAL NEEDS INTELLIGENTLY, PLAN TREATMENT AND ARRANGE FOR YOUR INVESTMENT IN THE PLAN.

IT IS A PLEASURE TO SURVEY YOUR DENTAL NEEDS AND DISCUSS THEM WITH YOU. SHOULD YOU CHOOSE OUR OFFICE TO PROVIDE YOUR DENTAL CARE, PLEASE BE ASSURED THAT THE MOST THOROUGH, CONSCIENTIOUS SERVICE WILL BE DEDICATED TO THIS TRUST. ALL FACILITIES AND PERSONNEL OF THIS OFFICE ARE EXPRESSLY HERE TO SERVE YOU AND YOUR HEALTH.

I CONSENT TO THE PERFORMANCE OF NECESSARY AND INDICATED DENTAL OPERATIONS AND PROCEDURES, AND TO THE ADMINISTRATION OF SUCH SEDATIVES AND ANESTHETICS AS MAY BE CONSIDERED NECESSARY OR ADVISABLE TO BRUCE VALENTINE, D.D.S.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

HOW CAN WE HELP YOU TODAY? _____