



Health History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name Birth date Age

Why are you now seeking dental treatment?

Please answer each question. Check "yes" or "no". If in doubt, leave blank.

1. Are you in good health now? Yes No

2. Are you now under the care of a physician? Yes No

If so, what is the condition being treated?

3. Have you ever been hospitalized or had serious illness? Yes No

If yes, please explain.

4. Have you had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?

5. (Woman) Are you pregnant? If so, give due date Yes No Due Date:

6. Do you use tobacco in any form? Yes No

If yes, how much?

7. Do you use alcoholic beverages (more than 2 drinks per day)? Yes No

8. Do you have or have you had any of the following :

	General		Heart / Blood Vessels		
Tire easily, weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marked weight change	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Night sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chest pain/discomfort	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Persistent fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart attack / trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Shortness of breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Swelling of ankles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Congenital heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Mitral valve prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Artificial heart valve	Yes <input type="checkbox"/>	No <input type="checkbox"/>



Health History Continued

Name Birth date Age

(To maintain record accuracy, please re-state your name and birth date at the top of this form)

	Nose		Heart / Blood Vessels Cont.	
Frequent nosebleeds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Throat			
Soreness / hoarseness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Heart attack / trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Nervous System		Bone / Muscles	
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis / rheumatism	Yes <input type="checkbox"/> No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Artificial joints/ limbs	Yes <input type="checkbox"/> No <input type="checkbox"/>

			Digestive System	
Convulsions/epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Numbness / tingling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness/fainting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psychiatric treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Change in appetite	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Respiratory			
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Black, bloody pale stools	Yes <input type="checkbox"/> No <input type="checkbox"/>

			Urinary	
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma / hayfever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Increase in frequency of urination (night)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Persistent cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Burning on urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sputum production (phlegm)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Urethral discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough up bloody sputum	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bloody urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty breathing while laying down	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Venereal disease	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Endocrine		Blood	
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bruise easily	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family history of diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid condition / goiter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Other			
Radiation therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV+	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tumors or growths	Yes <input type="checkbox"/>	No <input type="checkbox"/>	AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>

