



## HEALTH HISTORY

Mr. Mrs. Dr. Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

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

Are you currently receiving medical 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. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	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/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes

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

Women: Are you pregnant? No    Yes

If no, are you planning a pregnancy in the near future? No    Yes

Are you a nursing mother? No    Yes

Are you taking birth control pills? No    Yes

Abnormal Blood Pressure? (Please circle) No    Yes

If yes, what is it usually:    S            /D

Are you allergic or have you had a reaction to:

a. Local anesthetics ..... No    Yes

b. Penicillin or other antibiotics ..... No    Yes

c. Aspirin ..... No    Yes

d. Codeine, valium or other sedatives..... No    Yes

e. Other \_\_\_\_\_

Are you a smoker? No    Yes

If so, how much do you smoke per day? \_\_\_\_\_



Please list any medications you are currently taking:

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

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

What is your major reason for today's office visit? \_\_\_\_\_

Are you in pain or do you have any urgent concerns? \_\_\_\_\_

Are you happy with the appearance of your teeth? No Yes

Would you like to discuss changing the appearance of your teeth? No Yes

What don't you like about your smile? \_\_\_\_\_

Would you like to discuss how to make your teeth whiter? \_\_\_\_\_

**Doctor Notes**

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*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

\_\_\_\_\_  
*Patient (Print Name)*

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

\_\_\_\_\_  
*Date*