HEALTH HISTORY

Your physician's name_____ Address_____ Phone_____

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery) Yes ☐ No ☐

If so, what was the problem?_____

Have you had any form of cancer? Yes ☐ No ☐ If so, what type or name?_____

Date of last medical check up _____ Attending physician _____

Date of last blood test _____ Attending physician _____

Under a physician's care now? Yes ☐ No ☐ If so, for what?_____

What tablets, pills or liquids do you take? (that includes aspirin, vitamins, tonics, etc.)_____

_____

Does your physician require you to take special medication before dentistry? Yes ☐ No ☐ If so, what?_____

_____

Date and year of birth _____ Husband's (or wife's) date and year of birth _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO
Rheumatic fever, rheumatic heart disease	☐	☐
Heart trouble, heart attack, high blood pressure, stroke	☐	☐
Heart murmur, mitral valve prolapse	☐	☐
Pain in chest, shortness of breath, swollen ankles	☐	☐
Blood disorders, anemia	☐	☐
Cold sores or herpes incident	☐	☐
Positive test for venereal disease within five years	☐	☐
Positive test for AIDS virus	☐	☐
Abnormal bleeding, prolonged healing, bruises easily	☐	☐
Asthma, hay fever	☐	☐
Low blood pressure	☐	☐
Fainting spells, seizures	☐	☐
Hepatitis, jaundice, liver disease	☐	☐
Arthritis	☐	☐
Have you had an orthopedic joint replacement	☐	☐
Have you had an organ transplant	☐	☐
Kidney troubles	☐	☐

		YES	NO
Tuberculosis, other lung ailments		☐	☐
Persistent cough, cough up blood		☐	☐
Diabetes		☐	☐
Radiation treatment for a tumor or other growth		☐	☐
Sores that did not heal within one week		☐	☐
Women: Are you pregnant		☐	☐
Do you smoke		☐	☐
Are you sensitive or allergic to:	Penicillin	☐	☐
	Codeine	☐	☐
	Novocaine	☐	☐
	Aspirin	☐	☐
	Other anesthetics	☐	☐
	Other drugs	☐	☐
Do you have any disease, condition or problem not listed above that you think the doctor should know about?		☐	☐

_____

_____ _____

Patient's Signature Date

DATE	DOCTOR'S NOTES AND UPDATES ON HEALTH HISTORY

PERSONAL INFORMATION of _____ Date _____

The personal information will help us to give you the most consideration of your time and feelings.
It is important to have complete answers. All information is, of course, confidential.

Are you aware of having any particular dental problems? _____

_____

Are you having any discomfort or pain? _____

How long has it been since you last visited a dental office? _____

What was done for you at that time? _____

May we ask who recommended this office? _____

Your name _____ First name, husband (or wife) _____

Home address _____ City _____ Zip _____

Home phone _____ Occupation? _____ Social Sec. No. _____

For what company do you work? _____

Phone _____ Ext. _____ Cell Phone _____

Are you covered by any kind of dental insurance? Yes ☐ No ☐ E-mail address _____

If so, what insurance _____

Relationship to Policy Holder self spouse child other

Social Security Number: _____

Subscriber / Policy Holder

Name: _____

Address: _____

City / State / Zip: _____

Employee ID Number _____

OR

Social Security Number: _____

Group / Policy Number: _____

Phone Number to Verify Benefits: _____

DATE	DOCTOR'S NOTES AND UPDATES ON PERSONAL INFORMATION