CONFIDENTIAL HEALTH HISTORY

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 _____

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

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

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

Reason for medication _____

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS**
**Please circle yes or no**

Rheumatic fever, rheumatic heart disease_____ Y N
(please circle one)
Heart trouble _____ Y N
Heart attack_____ Y N
High Blood Pressure_____ Y N
Stroke _____ Y N
Heart Murmur _____ Y N
Mitral Valve Prolapse _____ Y N
Pain in chest, shortness of breath, swollen ankles ___ Y N
(please circle one)
Blood disorders, anemia _____ Y N
(please circle one)
Cold sores or herpes incident _____ Y N
(please circle one)
Positive test for venereal disease within five years __ Y N
Positive test for AIDS or HIV _____ Y N
Sexually transmitted disease _____ Y N
Abnormal bleeding, prolonged healing, bruises easily Y N
(please circle one)
Asthma, hay fever _____ Y N
(please circle one)
Low blood pressure _____ Y N
Fainting spells, seizures/epilepsy _____ Y N
(please circle one)
Hepatitis, jaundice, liver disease _____ Y N
(please circle one)
Arthritis _____ Y N
Kidney Trouble_____ Y N
Transfusions _____ Y N

Tuberculosis, other lung ailments /respiratory disorder____ Y N
(please circle one)
Persistent cough, cough up blood _____ Y N
(please circle one)
Diabetes _____ Y N
Radiation treatment for a tumor or other growth _____ Y N
Sores that did not heal within one week _____ Y N
Women: Are you pregnant _____ Y N
Do you smoke? If so, how much _____ Y N
Do you use smokeless tobacco? _____ Y N
If so, how much _____
Have you had an orthopedic joint replacement _____ Y N
Thyroid Disorder _____ Y N
Stomach Ulcer _____ Y N
Have you had an organ transplant _____ Y N

**Are you sensitive or allergic to**: **Penicillin** Yes ___ No ___

**Codein**e Yes ___ No ___ **Novocaine** Yes ___ No ___

**Aspirin** Yes ___ No ___ **Latex** Yes ___ No ___

**Metal/Nickel** Yes ___ No ___

**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 (or parent if minor) Date**

**CONFIDENTIAL MEDICAL HISTORY**

**NAME** _____ **DATE** _____

Date of Birth _____/_____/_____ Gender: ___Male ___Female

Email address: _____

Home address: _____ City _____State _____ Zip _____

Home phone: _____Cell: _____ Work phone: _____Ext._____

For what company do you work: _____Occupation: _____

If married, name of spouse: _____ Occupation of spouse: _____

Place of employment of spouse: _____ Work phone of spouse: _____Ext. _____

**Who is to be notified in case of emergency: _____Relationship _____ Phone #_____**

Are you aware of 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? _____

Physician's name: _____ Address: _____

Physician's telephone number: _____

**May we: Discuss your dental condition with any member of the family or designated representative? Yes ____ No ____**
**If yes, whom: _____ Relationship: _____**
**Their phone number: _____**

**Signature: _____ Date: _____**

**IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE REQUEST A 24-HOUR NOTICE.**

DATE DOCTOR'S NOTES AND UP-DATES ON PERSONAL INFORMATION