HEALTH HISTORY

MEDICAL HEALTH FORM:(patients name)_____ **Age:**_____

General Health: Excellent O Good O Fair O Poor O

Name, Phone Number of Physician: _____

Current Medications: _____

_____

Do you now have or have you ever had any of the following diseases or problems?

Heart Disease……..	Y	N	Cancers/Tumors……	Y	N
Heart Murmur……	Y	N	Radiation Therapy……..	Y	N
Congenital Heart Problems….	Y	N	Hepatitis/Jaundice……..	Y	N
Rheumatic Fever……	Y	N	AIDS……	Y	N
Artificial Joints……	Y	N	Epilepsy……..	Y	N
Abnormal Blood Pressure…….	Y	N	Fainting Spells……	Y	N
Stroke……	Y	N	Anemia……..	Y	N
Diabetes……	Y	N	Bruise Easily……..	Y	N
Tuberculosis/Lung Disease…..	Y	N	Stomach Ulcers……	Y	N
Bleeding Problems……	Y	N	Sinus Problems……..	Y	N
Drug Abuse……..	Y	N	Cough……..	Y	N
Excessive Urination……	Y	N	Arthritis……	Y	N
Excessive Thirst……	Y	N	Alcoholism……	Y	N
Hives/Skin Rash……..	Y	N	Currently Pregnant……	Y	N
Asthma/Hay Fever……..	Y	N	Allergies……..	Y	N

To What?_____

Is there anything else about your health that we should know?_____

_____

DENTAL HEALTH

Last Dental Visit:_____For What?_____
Any serious problems with dental treatment?_____
Does dental treatment make you nervous? No Somewhat Extremely

Do you now have or have you had any of the following problems?

Gum Disease……..	Y	N	Clicking/Popping Jaw……	Y	N
Bleeding/Sore Gums……..	Y	N	Difficulty Opening Jaw……..	Y	N
Bad Taste/Bad Breath……	Y	N	Clenching/Grinding……	Y	N
Loose/Shifting Teeth……	Y	N	Painful Chewing Muscles……	Y	N
Change in Bite……..	Y	N	Teeth Sensitive to Hot/Cold…….	Y	N
Blisters on Lips or Mouth…….	Y	N	Teeth Sensitive to Sweets…….	Y	N
Swelling or Lumps in Mouth….	Y	N	Teeth Sensitive to Biting……..	Y	N

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient, Parent or Guardian:_____Date:_____

Reviewed by:_____Date Date:_____