HEALTH HISTORY Name_____

I. Check Appropriate Answers: (Leave blank if you do not understand the question)

Yes No

1. Is your general health good? _____
2. Has there been a change in your health within the last year? _____
3. Have you been hospitalized or had a serious illness in the last three years? _____
   Please explain_____
4. Are you being treated by a Physician now? _____
   Please explain_____
   Date of last general exam ____/_____/_____Date of last Dental exam____/____/____
5. If yes to 4 above, name of **Medical Doctor**_____
   Phone Number (_____)_____
6. Have you had problems with prior dental treatment?
   Please explain_____
7. Are you in pain now? Explain_____

II. Have You Experienced?

Yes	No			Yes	No		
		8.	Chest pain (angina)?			19.	Dizziness?
		9.	Swollen ankles			20.	Ringing in the ears?
		10.	Shortness of breath?			21.	Headaches?
		11.	Recent weight loss, fever, night sweat?			22.	Fainting spells?
		12.	Persistent cough, coughing up blood?			23.	Blurred vision?
		13.	Bleeding problems, bruising easily?			24.	Seizures?
		14.	Sinus problems?			25.	Excessive thirst?
		15.	Difficulty swallowing?			26.	Frequent urination?
		16.	Diarrhea, constipation, blood in stools?			27.	Dry mouth?
		17.	Frequent vomiting, nausea?			28.	Jaundice?
		18.	Difficulty urinating, blood in urine?			29.	Joint pain, stiffness?

III. Do you Have Or Have You Had:

Yes	No			Yes	No		
		30.	Heart disease? Explain_____			41.	AIDS or ARC?
		31.	Heart attack? Explain_____			42.	HIV positive
		32.	Heart murmur?			43.	VD (syphilis or gonorrhea)?
		33.	High Blood pressure?			44.	Herpes?
		34.	Stroke, hardening of arteries?			45.	Skin diseases?
		35.	Rheumatic fever?			46.	Eye disease?
		36.	TB, emphysema, other lung diseases?			47.	Anemia
		37.	Hepatitis, other liver disease?			48.	Arthritis, rheumatism?
		38.	Stomach problems, ulcers?			49.	Kidney, bladder disease?
		39.	Allergies to: drugs, food, medications? _____			50.	Thyroid, adrenal disease?
		40.	Family history of diabetes, heart problems, tumors?			51.	Diabetes?

IV. Do You Have Or Have You Had:

Yes	No		
		52.	Tumors, cancer?
		53.	Radiation treatments?
		54.	Chemotherapy?
		55.	Prosthetic heart valve?
		56.	Latex Allergy?
		57.	Artificial joint?
		58.	Contact lenses?
		59.	Have you taken phen-phen or diet pills
		60.	Blood transfusions?
		61.	Surgeries?
		62.	Pacemaker?
		63.	Psychiatric care?

V. Are You Taking:

Yes	No		
		64.	Have you ever taken any cancer medications containing bisphosphonates? (Fosamax, Boniva, Actor
		65.	Recreational drugs? (Addiction)
		66.	Tobacco in any form?
		67.	**Medications** (including Aspir

Please list_____

_____

_____

Yes	No		
		68.	Are you or could you be pregnant or nursing?
		69.	Taking birth control pills?

VI. All Patients:

Yes No

70. Do you have had any other diseases or medical problems NOT listed on this form?
    Please explain_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Blue House Dentistry of any change/changes in my health and or medication.

Date____/____/_____Patient's Signature_____Doctor_____

RECALL REVIEW

1. Date____/____/____Medical Changes_____ Patient's Signature_____Doctor_____
2. Date____/____/____Medical Changes_____ Patient's Signature_____Doctor_____
3. Date / / Medical Changes Patient's Signature Doctor