

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		YES	NO
Rheumatic fever, rheumatic heart disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis, other lung ailments _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack, high blood pressure, stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough, cough up blood _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur, mitral valve prolapse _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain in chest, shortness of breath, swollen ankles _____	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment for a tumor or other growth _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders, anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Sores that did not heal within one week _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores or herpes incident _____	<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
Positive test for venereal disease within five years _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke _____	<input type="checkbox"/>	<input type="checkbox"/>
Positive test for AIDS virus _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you sensitive or allergic to: Penicillin _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding, prolonged healing, bruises easily _____	<input type="checkbox"/>	<input type="checkbox"/>	Codeine _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine _____	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells, seizures _____	<input type="checkbox"/>	<input type="checkbox"/>	Other anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice, liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition or problem not listed above that you think the doctor should know about? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an orthopedic joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had an organ transplant _____	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney troubles _____	<input type="checkbox"/>	<input type="checkbox"/>	Patient's Signature	Date	

DATE	DOCTOR'S NOTES AND UPDATES ON HEALTH HISTORY

