

# Health History

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaires. Please answer the questions as accurately as you can. If you have any questions or doubts, check the "not sure / maybe" choice. Your responses will be reviewed with you by the dentist and you can be assured that the information that you provide will be kept in the strictest confidence.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Has there been any changes in your health during the last 3 years?  No  Yes  Not Sure/Maybe

Have you had any illness or operation that required hospitalization?  No  Yes  Not Sure/Maybe

Do you have damaged heart valves, artificial heart valves, plastic or artificial arteries, cardiac pacemaker?  No  Yes  Not Sure/Maybe

Do you have Congenital heart defect(s) or murmur?  No  Yes  Not Sure/Maybe

Do you have or have you ever had chest pain, heart attack, Coronary insufficiency, coronary occlusion, arteriosclerosis or stroke?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Low Blood Pressure?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Liver disease or jaundice?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Stomach Diseases?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Fainting spells, seizures or epilepsy?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Venereal diseases?  No  Yes  Not Sure/Maybe

Do you have or have you ever had A.I.D.S.?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Nervous Breakdown or Psychotherapy?  No  Yes  Not Sure/Maybe

Do you bleed easily, bruise easily, or have you had abnormal bleeding with previous extractions or surgery?  No  Yes  Not Sure/Maybe

Do you ever been told to take antibiotics prior to dental treatment?  No  Yes  Not Sure/Maybe

Please list all ongoing medical problems: \_\_\_\_\_

Are you allergic or have you reacted adversely to any medication, food or substances?  No  Yes  Not Sure/Maybe

To the best of your knowledge, has any blood relative had a bad reaction to anesthetic?  No  Yes  Not Sure/Maybe

Do you drink wine, spirit, beer or any other alcoholic beverage every day?  No  Yes

For women only, are you pregnant?  No  Yes  Not Sure/Maybe

Do you have a family physician?  No  Yes

When was your last complete physical check up? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

If yes, what was the illness or operation? \_\_\_\_\_

Do you have knee or hip replacement?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Rheumatic heart disease, SLE or other systemic rheumatism?  No  Yes  Not Sure/Maybe

Do you have or have you ever had High Blood Pressure?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Respiratory trouble, shortness of breath, asthma, pneumonia or COPD?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Kidney Diseases?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Diabetes?  No  Yes  Not Sure/Maybe

Do you have or have you ever had any allergies?  No  Yes  Not Sure/Maybe

Do you have or have you ever any form of Hepatitis?  No  Yes  Not Sure/Maybe

Do you have or have you ever had Tuberculosis or a persistent cough or cough up blood?  No  Yes  Not Sure/Maybe

Do you have or have you ever had any blood disorder such as anemia?  No  Yes  Not Sure/Maybe

Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?  No  Yes  Not Sure/Maybe

Do you taken any "street drugs" in the past such as cocaine, crack, LSD?  No  Yes  Not Sure/Maybe

Please list all medications you are taking now: \_\_\_\_\_

If yes, what are the medication, food and substances? \_\_\_\_\_

Do you smoke?  No  Yes

Do you have a history of alcoholism or drug dependence?  No  Yes  Not Sure/Maybe

If yes, when is the due date? \_\_\_\_\_

If yes, please provide his/her name, address and phone number. \_\_\_\_\_

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