Confidential Health History

Patient Name: ____ **Date of Birth:** ___________________

I. Circle Appropriate Answer (Leave blank if unsure of the answer)

1.	Yes	No	Is your general health good? If NO, explain: ________________________________
2.	Yes	No	Has there been a change in your health within the last year? If YES, explain: ________________________________
3.	Yes	No	Have you gone to the hospital or emergency room or had a serious illness in the last 3 years? If YES, explain: ________________________________
4.	Yes	No	Are you being treated by a physician now? If YES, explain: ________________________________

5. Date of last medical exam? __________________ Reason for exam: ________________________________

II. Have you experienced any of the following? (Please Circle)

Chest pain (angina)	Blood in stool	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. Have you had or do you have any of the following? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis A / B / C
Heart defects	Tumors or cancer	STIs/STDs
Heart murmur	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung diseases	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. Are you allergic to or have you had a reaction to any of the following? (Please Circle)

Valium	Vicodin	Tetracycline	Codeine	Penicillin	Nitrous Oxide	Erythromycin
Metal	Latex	Local anesthetic (Novocaine or Xylocaine)			Other: ______________________	

V. Are you taking or have you taken any of the following in the last three months? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics	Over-the-counter medicines	Alcohol supplements
Weight loss medication	Aspirin	Bisphosphonate (Fosamax)	Other: ______________________	

VI. Women Only

Yes	No	Are you or could you be pregnant?	If YES, which month? ____________________
Yes	No	Are you nursing?	
Yes	No	Are you taking birth control pills?	

VII. All Patients

Yes	No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, explain: ________________________________	
Yes	No	Have you ever been required to pre-medicate prior to dental treatment?	If YES, why: ______________
Yes	No	Have you ever taken Fen-phen?	If YES, when: ______________
Yes	**No**	**Are there any issues or conditions that you would like to discuss with the dentist in private?**	

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician's Name: ____________________________________ Phone Number: ________________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately.I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____ ____________________________

Signature of Patient (Parent or Guardian) **Date**