Confidential Health History

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question) 1. Yes / No Is your general health good? If NO, explain:	Patient	Name:			Date of Birth:					
1. Yes / No Is your general health good? If NO, explain:				1.1						
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 three years? If YES, explain: 2. Yes / No Have you being treated by a physician now? If YES, explain: Date of last medical exam? Reason for exam: 5. Yes / No Have you had problems with prior dental treatment? If YES, explain: Date of last dental exam: Date of last dental exam: Name of last treating dentist: 6. Yes / No Are you in pain now? If YES, explain: Have you for longin(a) Yes / No Are you in pain now? If YES, explain: Name of last treating dentist: 6. Yes / No Are you in pain now? Yes / No Frequent vomiting yes / No Yes / No Frequent vinction Yes / No Recent significant weight loss Yes / No Yes / No Recent significant weight loss Yes / No Yes / No Recent significant weight loss Yes / No Yes / No Recent significant weight loss Yes / No Yes / No			•	k if you do ne	ot understand the question)					
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If YES, explain:			If YES, explain:							
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Date of last dental exam:	5.	103 / 140								
 6. Yes / No Are you in pain now? If YES, explain:										
If YES, explain:	,				Name of last freating de	nfisf:				
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each) Yes / No Chest pain (angina) Yes / No Blood in stools Yes / No Frequent vomiting Yes / No Fainting spells Yes / No Diarrhea or constipation Yes / No Jaundice Yes / No Recent significant weight loss Yes / No Diarrhea or constipation Yes / No Dry mouth Yes / No Recent significant weight loss Yes / No Difficulty urinating Yes / No Excessive thirst Yes / No Persistent cough Yes / No Headaches Yes / No Swallen ankles Yes / No Dersistent cough Yes / No Blurred vision Yes / No Soullen ankles Yes / No Bleding problems Yes / No Blured vision Yes / No Soullen ankles Yes / No Bleding problems Yes / No Burde vision Yes / No Soullen ankles Other:	6.	Yes / No								
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Other		Other:	Cosmenc surgery	162 / 140	Lanny aisoraers	162 / 140	100610010515			

IV. ARE YOU AL (Please circle Yes o	LERGIC TO OR HAVE YOU I r No for each)	HAD A REAC	TION TO ANY OF THE FOL	LOWING?			
Yes / No Yes / No	Aspirin Penicillin or other antibiotics		Valium or other sedatives Latex		Codeine or other narcotic Food		
	Nitrous oxide			Yes / No	Metal		
	KING OR HAVE YOU TAKEN es or No for each)	I ANY OF TH	HE FOLLOWING IN THE LA	ST THREE MO	NTHS?		
•	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics		
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements		
Yes / No Yes / No	Weight loss medications Anti-Depressants	Yes / No Yes / No	Bisphosphonate (Fosamax) Herbal Supplements	Yes / No	Aspirin		
	all prescription medications:						
VI. WOMEN ON	ILY (Please circle Yes or No for	· each)					
Yes / No	Are you or could you be pregnant? If YES, what month?						
Yes / No	Are you nursing?						
Yes / No	Are you taking birth control p	ills?					
VII. ALL PATIEN	TS (Please circle Yes or No for	each)					
Yes / No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:						
Yes / No	Have you ever been pre-medic	ated for denta	l treatment? If YES, why:				

Yes / No Have you ever taken Fen-Phen? If YES, when: ______

Yes / No Is there any issue or condition 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.

Patient's Signature:	Date:						
Physician's Name:	Phone Number:						
Physician's Address:							
Whom would you like us to contact in case of an emergency?							

Name:

Relationship: _____

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 change 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

Signature of Dentist

Date