Confidential Health History

Patient Name: ____ Date of Birth: __________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

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 three years?
   If YES, explain: ____

4. Yes / No Are 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:________________ Name of last treating dentist:______________________

6. Yes / No Are you in pain now?
   If YES, explain: ____

7. Yes / No Are you on blood thinners?
   If YES, explain: ____

II. HAVE YOU 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	Jaundice
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation
Yes / No	Recent significant weight loss	Yes / No	Frequent urination
Yes / No	Dry mouth	Yes / No	Excessive thirst
Yes / No	Fever	Yes / No	Difficulty urinating
Yes / No	Night sweats	Yes / No	Ringing in ears
Yes / No	Persistent cough	Yes / No	Headaches
Yes / No	Swollen ankles	Yes / No	Difficulty swallowing
Yes / No	Coughing up blood	Yes / No	Dizziness
Yes / No	Joint pain or stiffness	Yes / No	Blurred vision
Yes / No	Bleeding problems	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily
Yes / No	Sinus problems	Yes / No	Anxiety

(Continued on the next page)

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV
Yes / No	Psychiatric care	Yes / No	Osteoporosis
Yes / No	Family history of heart disease	Yes / No	Surgeries
Yes / No	Heart attack	Yes / No	Hospitalization
Yes / No	Thyroid disease	Yes / No	Asthma
Yes / No	Artificial joint	Yes / No	Diabetes
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes
Yes / No	Hepatitis	Yes / No	Sexual transmitted disease
Yes / No	Herpes	Yes / No	Tumors or cancer
Yes / No	Heart murmurs	Yes / No	Chemotherapy
Yes / No	Heart defects	Yes / No	Rheumatic fever
Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism
Yes / No	Anemia	Yes / No	Hardening of arteries
Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease
Yes / No	Eye disease	Yes / No	Cosmetic surgery
Yes / No	Seizures	Yes / No	Stroke
Yes / No	Transplants	Yes / No	Eating disorders
Yes / No	Tuberculosis	Yes / No	Implants

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic	Yes / No	Erythromycin	Yes / No	Metal

Others: ______________________________

____

V. WOMEN ONLY (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 pills?

(Continued on the next page)

VI. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No	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	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list ALL prescription medications and reason for taking prescription:

Medication:	Taken For:

OFFICE USE ONLY:
- ☐ Routed to Dr. Henderson for review _________ (Staff initials)
- ☐ Reviewed by Dr. Henderson _____________ (Date) _____________(Dr.'s initials)
- ☐ Dental Side Effects and Epi Contra Sheet created (see chart for copy if checked)

(Continued on the next page)

VII. ALL PATIENTS (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-medicated for dental 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: ____________________

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

OFFICE USE ONLY: **MEDICAL RELEASE REQUEST**

- ☐ Faxed over medical release to pt's doctor______________ (Date) _____________(Staff initials)
- ☐ Reviewed by Dr. Henderson __________________ (Date) _____________(Dr.'s initials)
- ☐ Copy of reviewed medical release form is in chart and information is flagged in computer.