EMERYVILLE DENTAL CARE
PATIENT HEALTH HISTORY Confidential Information

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Patient Name: _____ Social Security Number: _____-_____-_____
Patient Address: _____ City _____ State _____ Zip _____
Birth Date: ___/___/___ Pulse: _____ Regular/Irregular Blood Press: ____/____(L) ____/____(R) Height ___'___' Weight: _____lbs

I. CIRCLE APPROPRIATE ANSWER (Please answer all & leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what condition?_____
   Name, Address & Phone No. of your Physician:_____
   Date of last medical exam?_____ Last Blood Test?_____ Date of last Dental Appointment:_____
5. Yes No Have you had problems with prior dental treatment? Why?_____
6. Yes No Are you in pain now? Where?_____ Describe?_____

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)? How often? _____
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems? Medications: _____
14. Yes No Difficulty swallowing?
15. Yes No Persistent Diarrhea, Constipation? Blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Jaw problems TMJ/TMD?
19. Yes No Back Problems? Medications: _____
20. Yes No Dizziness?
21. Yes No Ringing in ears?
22. Yes No Headaches? Severe/Frequent
23. Yes No Fainting spells?
24. Yes No Blurred vision?
25. Yes No Seizures? Epilepsy? Grand Mal or Petite. How often? _____
26. Yes No Excessive thirst?
27. Yes No Frequent urination?
28. Yes No Dry mouth?
29 Yes No Jaundice?
30. Yes No Joint pain, stiffness?
31. Yes No Shingles?
32. Yes No Nervousness?
33. Yes No Insomnia?
34. Yes No Sleep Apnea?

III. DO YOU HAVE OR HAVE YOU HAD:

35. Yes No Heart disease?
36. Yes No Heart attack? Heart defects? Congenital Heart Defect?
37. Yes No Heart murmurs?
38. Yes No Rheumatic fever?
39. Yes No Stroke, hardening of arteries?
40. Yes No Mitral Valve Prolapse? Damage Heart Valve?
41. Yes No High/Low Blood pressure? Medications:_____
42. Yes No Scarlet Fever?
43. Yes No Family history of diabetes, heart problems, tumors?
44. Yes No Hepatitis, other liver disease? Medications: _____
45. Yes No Stomach problems, ulcers? Medications: _____
46. Yes No Allergies to: drugs, foods, medications, latex?
47. Yes No Asthma, TB, emphysema, other lung diseases?
    What triggers your asthma? _____
    Medications? _____
48. Yes No AIDS or ARC? or HIV+?,
    When will you take your HIV blood test? _____
49. Yes No Tumors, cancer?
50. Yes No Arthritis, rheumatism?
51. Yes No Eye diseases? Glaucoma? Medications_____
52. Yes No Skin diseases?
53. Yes No Anemia? Bruise easily?
54. Yes No Hemophiliac? Sickle Cell Disease?
55. Yes No VD (syphilis or gonorrhea)?
56. Yes No Herpes?
57. Yes No Kidney, bladder disease?
58. Yes No Thyroid, adrenal disease?
59. Yes No Diabetes? Type I or Type II Medications: _____
60. Yes No Liver Problems?
61. Yes No the drug Phen-fen &/or Redux? When? _____

IV. DO YOU HAVE OR HAVE YOU HAD:

62. Yes No Pacemaker?
63. Yes No Radiation treatments? Chemotherapy?
64. Yes No Neurological Disorders?
65. Yes No Prosthetic (Artificial) heart valve?
66. Yes No Artificial joint? (hip, knee, or other joints)
66. Yes No Biphosphonates (Ex: Boniva, Fosamax, Didronel, Actonel, Reclast
67. Yes No Hospitalization? Year(s)_____ For_____
68. Yes No Blood transfusions? Year(s)_____
69. Yes No Surgeries? Year(s) _____ For _____
70. Yes No Psychiatric care, Psychiatric Problems?
71. Yes No Contact lenses?

V. ARE YOU TAKING:

72. Yes No Recreational drugs? How often? _____
73. Yes No Tobacco in any form? How many per day? _____
74. Yes No Alcoholic Beverages? How Often? _____
75. Yes No Drugs, medications, OTC medicines (including Aspirin), natural remedies? Please list medications (and reason for taking):
    _____
76. Yes No Antacids? How often? _____
77. Yes No St. John's Wort Antifungal?
78. Yes No Herbal Supplements? Herbal Drinks?

VI. WOMEN ONLY:

79. Yes No Are you or could you be pregnant or nursing?
80. Yes No Taking birth control pills (BCP?) (use another form of BCP while taking antibiotics such as but not limited to, Penicillin, Amoxicillin, and /or Clindamycin)
81. Yes No Are you planning a pregnancy in the next 6 mos/12 mos?

VII. ALL PATIENTS: 82. How often do you eat? _____ 83. How often do you drink cranberry juice? _____ grapefruit juice?_____
84. Do you take any other anti-oxidants (list) ? _____ 85. Health drinks (list)? _____ " last 48 hrs? _____
86. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    If so, please explain: _____

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.
"Your Smile Starts Here…"☺ Get the Healthy Smile You Deserve.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature _____ Date: _____
2. Patient's signature _____ Date: _____
3. Patient's signature _____ Date: _____