Confidential Health History Form

Patient Name: _____ **Date of Birth:**_____ **Today's Date:**_____

Circle appropriate answers

1. YES NO Is your general health good? If NO, explain_____
2. YES NO Do you have any known heart conditions? If YES, explain_____
3. YES NO Have you gone to the hospital or emergency room or had 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. YES NO Are you in pain now? If YES, explain_____
6. YES NO Do you smoke? If YES, how often?_____
7. YES NO Do you have diabetes? If yes, is it controlled?_____

Have you experienced any of the following in the past 2 months?

YES--NO chest pain	YES--NO difficulty swallowing	YES--NO bleeding problems
YES--NO fainting spells	YES--NO frequent vomiting	YES--NO dry mouth
YES--NO shortness of breath	YES--NO excessive thirst	YES--NO persistent cough
YES--NO sinus problems	YES--NO fever	YES--NO headaches

Have you had or do you have any of the following?

YES--NO heart disease	YES--NO high blood pressure	YES--NO stroke
YES--NO heart attack	YES--NO immune disorder	YES--NO osteoporosis
YES--NO artificial joint	YES--NO anemia	YES--NO asthma
YES--NO stomach ulcers	YES--NO cancer, chemo/radiation	YES--NO hepatitis
YES--NO heart murmer	YES--NO thyroid disease	YES--NO herpes or cold sores
YES--NO skin disease	YES--NO kidney or bladder disease	YES--NO eye disease
YES--NO seizures	YES--NO emphysema, lung disease, TB	YES--NO AIDS/HIV
YES--NO depression/emotional condition	YES--NO anxiety	YES—NO Covid-19

Are you allergic to or have you had a reaction to any of the following?

YES--NO aspirin	YES--NO valium	YES--NO tetracycline
YES--NO penicillin	YES--NO codeine	YES--NO latex
YES--NO metals	YES--NO nitrous oxide	YES--NO local anesthetic (Novocaine, Lidocaine)

Other_____

Are you taking or have you taken any of the following in the past three months?

YES--NO recreational drugs	YES--NO aspirin	YES--NO antibiotics
YES--NO corticosteroids	YES--NO alcohol	YES--NO bisphosphonates (fosomax, boniva)

Please list all medications you are currently taking_____

_____

YES NO Do you have any medical conditions not listed on this form? If yes, explain_____

YES NO Have you ever been premedicated (antibiotics/anti-anxieties) for dental treatment? If yes, why?_____

YES NO I authorize the dentist to contact my physician if necessary for a consultation prior to dental treatment.

Women only:

YES NO Are you or could you be pregnant? If yes, what month_____ Are you nursing? YES NO

All patients: 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 or her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ _____

Signature of patient or legal guardian Date