PATIENT HEALTH HISTORY

Name: _____ Height: _____ Weight: _____ Sex: _____

Physician's Name: _____

What is your estimation of your general health? _____

Why are you now seeking dental treatment? _____

1. Have you been examined by your doctor within the last year?	YES	NO
2. Are you being treated by any condition by a doctor now?	YES	NO
3. Has there been any change in your general health in the past year?	YES	NO
4. Have you ever been told by a doctor that you have a heart murmur?	YES	NO
5. Have you ever had heart trouble?	YES	NO
6. Do you have high blood pressure?	YES	NO
7. Do you bleed for a long time when you cut yourself?	YES	NO
8. Do you have any blood disorder?	YES	NO
9. Do you have any chest pain on exertion?	YES	NO
10. Are you ever short of breath on mild exertion?	YES	NO
11. Do your ankles ever swell?	YES	NO
12. Do you have a tendency to faint?	YES	NO
13. Do you ever have fits or convulsions?	YES	NO
14. Do you ever have asthma?	YES	NO
15. Do you ever have hay fever?	YES	NO
16. Has a doctor ever said that you had liver disease?	YES	NO
17. Have you ever had sores on the mouth that are slow to heal?	YES	NO
18. Have you had any serious illness or operation?	YES	NO
19. Have you been hospitalized or had a serious illness within the past five years?	YES	NO

20. Have you ever experienced an unusual reaction to any of the following drugs:

a) Penicillin	Y N	b) Barbiturates	Y N	c) Aspirin	Y N	d) Codeine	Y N
e) Iodine	Y N	f) Sulfa Drugs	Y N	g) Other medicines	Y N	h) Local anesthetics	Y N

21. Women – Are you pregnant at the present time?	YES	NO

22. Have you ever been treated for any of the following conditions:

a) Rheumatic fever	Y N	b) Ulcers	Y N	c) Lung disease	Y N	d) Diabetes	Y N
e) Epilepsy	Y N	f) Scarlet fever	Y N	g) Venereal disease	Y N	h) Radiation treatment	Y N
i) Jaundice	Y N	j) Sinus trouble	Y N	k) Cough	Y N	i) Hepatitis	Y N
m) Arthritis	Y N	n) Stroke	Y N	o) Glaucoma	Y N	p) Tuberculosis	Y N

23. Are you taking any drug or medicine?	YES	NO
if so, what _____		
24. Do you have any disease, condition, or problems not listed above that you think I should know about	YES	NO

_____

Signature of Patient: _____