

# Confidential Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ 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 \_\_\_\_\_

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

**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 Cosmetic surgery                | Yes / No Eating disorders           |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis               |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease            |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                     |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                  |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                     |
| 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 Seizures                        | Yes / No Stroke                          | Yes / No Transplants                |
|  |  | Yes / No Tuberculosis               |

**This information will not be released unless specifically authorized by patient.**

Yes / No AIDS/HIV      Yes / No Anxiety      Yes / No Depression      Yes / No Treatment for emotional condition

**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<br>(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal         |

Others \_\_\_\_\_

