

# HEALTH HISTORY

Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Place a mark in the box for "Yes" or "No" to indicate if you have or have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Back or Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: Type ____	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet or Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/Steroid Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Taken the Diet Pill Fen-Phen?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride in your water	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fosamax, Zometa, Aredia or Actonel	<input type="checkbox"/>	<input type="checkbox"/>

## MEDICATIONS

List medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

## ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Metal
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Other _____	

## DENTAL HISTORY

	Yes	No		Yes	No
Reason for today's visit _____	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation tongue	<input type="checkbox"/>	<input type="checkbox"/>
_____			Clicking or popping jaw	<input type="checkbox"/>	<input type="checkbox"/>
Former Dentist _____			Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
City/State _____			Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental visit _____			Food collection between the teeth	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental X-rays _____			Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>
Place a mark on "Yes" or "No" to indicate if you have had any of the following:			Gums swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>
			Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>
			Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Chew on one one side of the mouth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>			
			How often do you floss? _____		How often do you brush? _____

Patients Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_