ENGLISH

Health History

Patient Name: _____ Soc. Sec. No. _____

Birth Date _____

I. CIRCLE APPROPRIATE ANSWER (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?
   Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last Medical Exam: _____ Date of last Dental Appt.: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
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?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in the ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS or ARC?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medicines, (incl. Aspirin)?
    Please list: _____
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. 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.

Patient's signature _____ Date _____

RECALL REVIEW:

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

PATIENT INFORMATION

Date_____

Name_____

Responsible party_____, Apt#_____

Address_____

City_____ Zip code_____

Home phone (____)_____ Work phone (____)_____

Date of birth_____ Age_____ Male ( ) Female ( )

Married ( ) Single ( ) Divorced ( ) Widowed ( )

Patient employer_____

Employer's address_____

City_____ Zip Code_____

GENERAL INFORMATION

1. Number of people in the household_____
2. Number of children in the household_____
3. How did you first hear about our office?_____
4. Is patient available on short notice? yes ( ) no ( )
5. Have you or any member of your family ever been a patient here? yes ( ) no ( )
   If yes: who?_____ when?_____
6. Since your last visit has there been any change in your: health ( ) telephone ( )
   employer ( ) name ( ) address ( ) explain_____
7. Name of physician_____
8. Date of patient last medical visit_____
9. Name of prior dentist_____
10. Date of patient last dental visit_____
11. Reason for last dental visit_____
12. Reason for this dental visit_____
13. Please check if you ever have had the following treatment:
    braces ( ) bridge ( ) cleaning ( ) crown ( ) denture ( ) extraction ( )
    filling ( ) partial ( ) root canal ( )
14. If you are having pain with a tooth, would you consider having root canal treatment to save your tooth? yes ( ) no ( )
15. If you have a tooth extracted, or if you have one or more missing teeth, are you interested in a replacement? yes ( ) no ( )
16. When did you last have your professional cleaning?_____
17. Do you ever notice your gums bleed when you brush your teeth? yes ( ) no ( )
18. What is the best day and time for your appointment?_____
19. Your dentist will start your treatment today. Please indicate how you prefer to pay for today's service? Insurance ( ) Medicaid ( ) Cash ( ) Check ( )
    Payment Plan ( ) Visa ( ) Master Card ( )

FOR OFFICE USE: QUESTIONNAIRE REVIEW BY_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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