Confidential Health History Form

Today's Date_____

I. Patient's Name: First _____ **MI** _____ **Last** _____ **Date of Birth**_____

Referred by _____ **Name of last treating dentist** _____ **Date of last exam** _____

II. Circle appropriate answer

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 please 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 please explain _____
4. Yes / No **Are you being treated by a physician now?**
   If YES, explain _____
5. Yes / No **Have you had problems with prior dental treatment?**
   If YES, explain _____
6. Yes / No **Have you ever had root planing (deep cleaning)?**
   If YES, When? _____
7. Yes / No **Have you ever had periodontal (gum) surgery?**
   If YES, When?_____

III. Have you ever experienced any of the following? (*Please circle Yes or No*)

Yes / No Chest pain (Angina)	Yes / No Sinus Problems	Yes / No Jaundice
Yes / No Fever	Yes / No Persistent Cough	Yes / No Significant weight loss
Yes / No Frequent Headaches	Yes / No Coughing up blood	Yes / No Frequent Urination
Yes / No Dizziness	Yes / No Bleeding Problems	Yes / No Dry Mouth
Yes / No Blurred Vision	Yes / No Blood in urine	Yes / No Excessive thirst
Yes / No Bruise easily	Yes / No Difficulty Swallowing	Yes / No Swollen ankles
Yes / No Joint pain or stiffness	Yes / No Shortness of breath	

IV. Have you had any of the following? (*Please circle Yes or No*)

Yes / No Heart Disease	Yes / No Osteoporosis	Yes / No Diabetes – Family History of Diabetes
Yes / No Heart Attack	Yes / No Thyroid disease	Yes / No Asthma
Yes / No Heart Murmurs	Yes / No Tumors or cancer	Yes / No Kidney or bladder disease
Yes / No Heart Defects	Yes / No Chemotherapy	Yes / No Arthritis, rheumatism
Yes / No High blood pressure	Yes / No Radiation Therapy	Yes / No Emphysema or other lung disease
Yes / No Stroke	Yes / No Hepatitis	Yes / No Liver disease
Yes / No Seizures	Yes / No Anemia	Yes / No Herpes - Canker or cold sores
Yes / No Transplants	Yes / No Dental Implant	Yes / No Artificial joint

This information will not be released.

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

V. Are you taking or have you taken any of the following in the last three months? (*Please circle Yes and No for each*)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (eg. Fosamax)	Yes / No Aspirin
Yes / No Cortico – Steroids	Yes / No Anti-depressants	Yes / No Anti-anxiety drugs
Yes / No NSAIDS		

Please list all medications you are currently taking (attached separate sheet if necessary) _____

_____

VI. 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 Darvon
Yes / No Codeine
Yes / No Latex
Yes / No Metal
Yes / No Nitrous Oxide
Yes / No Cortio – Steroids
Yes / No Metronidazole
Yes / No Sulfa Drugs

Yes / No Valium or Versed
Yes / No Demerol
Yes / No Penicillin
Yes / No Food
Yes / No Erythromycin
Yes / No Tylenol
Yes / No Ibuprofen
Yes / No Zithromax

Yes / No Tetracycline
Yes / No Vicodin
Yes / No Percodan
Yes / No Benadryl
Yes / No Local Anesthetic (Novocain or Xylocaine)
Yes / No Epinephrine
(Adrenalin causes rapid heart beat)
Yes / No Clindamycin (Cleocin)

Other medications not listed _____

VII. Women Only (*Please circle Yes or No for each*)

Yes / No Are you or could you be pregnant? If YES, what month _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?
Yes / No Have you gone through menopause?

VIII. All patients (*Please circle Yes or No for each*)

Yes/ No Do you have or have you had any other diseases or medical problems NOT listed in section II or III ?
If YES, explain_____

Yes / No Have you ever been pre-medicated for dental treatment?
If YES, reason_____

Yes / No Is there any issue or condition that you would like to discuss with Dr. Carson in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Dr. John Carson to contact my physician.

X Patient's Signature_____ Date_____

Physician's Name_____ Phone Number_____

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

X _____ _____ _____ _____
Signature of Patient (Parent of Guardian) Date Signature of Dentist Date

Reviewed by _____ Date _____
Medical updates – I have reviewed my Heath History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist/RDH Initial: